



# HEALTH

## TRANSFORMATION SUMMIT



Center for Health Transformation  
Better health, lower cost

AMERICAN LEGISLATIVE EXCHANGE COUNCIL

# PROGRAM HANDBOOK

## MARCH 14, 2006

FLORIDA HOUSE OF REPRESENTATIVES



# The Florida House of Representatives

Office of The Speaker

**Allan G. Bense**  
Speaker

420 Capitol Building  
(850) 488-1450

March 14, 2006

Dear Friends:

Thank you for joining me at the Florida House of Representatives for the Health Transformation Summit.

The Center for Health Transformation and the American Legislative Exchange Council have collaborated to bring you a diverse array of healthcare professionals who will direct today's dialogue during three breakout sessions. Discussion issues include: *Health Information Technology*, *Pandemic Preparation*, and *Promoting Access and Affordability through Consumerism*.

We are honored to have Former Speaker of the United States House of Representatives, Newt Gingrich, and Dr. David J. Brailer, National Coordinator for Health Information Technology, leading the conversation today. They will address methods that Floridians can use to transform the current healthcare system into an even better one.

The Florida House is very fortunate to have so many noted healthcare authorities participating in our Summit today. I trust you will obtain a wealth of knowledge from this special event.

Regards,

A handwritten signature in black ink that reads "Allan Bense". The signature is fluid and cursive, with the first name "Allan" and last name "Bense" clearly distinguishable.

Allan G. Bense  
Speaker

AGB:vj



## NEWT GINGRICH

Former Speaker Newt Gingrich is the founder of the Center for Health Transformation, a collaboration of leaders dedicated to the creation of a 21<sup>st</sup> Century Intelligent Health System that saves lives and saves money. He is also the founder of the Gingrich Group, a communications and consulting firm specializing in transformational change, and serves as a political analyst for FOX News Network, a senior fellow at the American Enterprise Institute in Washington, D.C. and a distinguished visiting fellow at the Hoover Institution at Stanford University in Palo Alto, California. Gingrich served as a Member of Congress for twenty years and as Speaker of the U.S. House of Representatives 1995-1999.

He is a board member of the Juvenile Diabetes Foundation, and serves with former Senator Bob Kerrey as Co-Chairman of the National Commission for Quality Long-Term Care. In addition, he is a member of the Advisory Board for the Agency for Healthcare Research and Quality and for the National Library of Medicine.

Mr. Gingrich received the 2005 Health Quality Award from the National Committee for Quality Assurance, an independent, non-profit organization whose mission is to improve health care quality. He has also been honored with the 2005 National Minority Health Month Foundation Award for his outstanding contributions to the elimination of diabetes, and with the 2005 Healthcare Information and Management Systems Society Advocacy Award for leadership in advancing information and management systems for the betterment of human health.

He received a bachelor degree from Emory University and a masters and doctorate degree from Tulane University in Modern European History. Before his election to Congress, he taught History and Environmental Studies at West Georgia College for eight years. He is recognized worldwide as an expert on world history, military issues and international affairs and is a member of the Secretary of Defense's Defense Policy Board. Mr. Gingrich is the longest-serving teacher of the Joint War Fighting course for Major Generals, and teaches officers from all five services as a Distinguished Visiting Scholar and Professor at the National Defense University. He also serves on the Terrorism Task Force for the Council on Foreign Relations, as an Editorial Board Member of the Johns Hopkins University journal, *Biosecurity and Bioterrorism*, and as an Advisory Board Member of the Foundation for the Defense of Democracies.

Mr. Gingrich is the author of nine books including the bestsellers, *Winning the Future*, *Contract with America* and *To Renew America*, as well as *Saving Lives and Saving Money*, which describes the Center for Health Transformation's 21<sup>st</sup> Century Intelligent Health System.

Mr. Gingrich resides in Virginia with his wife, Callista. He has two daughters and two grandchildren.

## **DR. DAVID J. BRAILER**

Dr. David J. Brailer was appointed the first National Health Information Technology Coordinator on May 6, 2004. Dr. Brailer's duties as National Coordinator are to execute the actions ordered by President George W. Bush in the Executive Order that he issued on April 27, 2004, which called for widespread deployment of health information technology within 10 years to help realize substantial improvements in safety and efficiency. Dr. Brailer is recognized as a leader in the strategy and financing of quality and efficiency in health care, with a particular emphasis on health information technology and health systems management.

Prior to his appointment, Dr. Brailer was a Senior Fellow at the Health Technology Center in San Francisco, CA, a non-profit research and education organization that provides strategic information and resources to health care organizations about the future impact of technology in health care delivery. At the Center, he advised a variety of regional and national data sharing projects.

Dr. Brailer also served for ten years as Chairman and CEO of CareScience, Inc., a leading provider of care management services and Internet-based solutions that help reduce medical errors and improve physician and hospital-based performance. While at CareScience, Dr. Brailer led the company in developing groundbreaking inventions with major research institutions, establishing the nation's first health care Application Service Provider (ASP) and creating a care management business process outsourcing partnership that allowed hospitals to outsource their care management functions on an at-risk basis. Dr. Brailer also designed and oversaw the development of one of the first community-based health information exchanges in Santa Barbara County, California.

Dr. Brailer holds doctoral degrees in both medicine and economics. While in medical school, he was a Charles A. Dana Scholar at the University of Pennsylvania, School of Medicine and was the first recipient of the National Library of Medicine Martin Epstein Award for his work in expert systems. Dr. Brailer was among the first medical students to serve on the Board of Trustees of the American Medical Association. He completed his medical residency at the Hospital of the University of Pennsylvania and became board certified in internal medicine along the clinical investigator pathway. Dr. Brailer was a Robert Wood Johnson Clinical Scholar at the University of Pennsylvania and, until recently, was active in patient care delivery with an emphasis on immune deficiency. He earned his M.D. degree at West Virginia University and his Ph.D. in managerial economics at The Wharton School.



**HEALTH TRANSFORMATION SUMMIT**  
**BREAKOUT SESSIONS**  
**10:30 a.m.-12:00 p.m.**

**HEALTH INFORMATION TECHNOLOGY**

Reed Hall, 102 House Office Building

**David Merritt**, Project Director, Center for Health Transformation

**Gerard White**, President, Clearwave

**Joan Hovhanesian**, Senior Vice President & Chief Information Officer, Shands  
Healthcare, University of Florida

**Timothy J. Yeatman**, MD, Associate Center Director for Translational Research and  
Director of Total Cancer Care, H. Lee Moffitt Cancer Center & Research Institute

**W. Michael Heekin**, Chair, Governor's Health Information Infrastructure Advisory  
Board

**PANDEMIC PREPARATION**

Morris Hall, 17 House Office Building

**Robert Egge**, Project Director, Center for Health Transformation

**M. Rony Francois**, MD, MSPH, PhD, Secretary, Florida Department of Health

**Russell Fendley**, Senior Vice President of Government Affairs, FHC Health System

**Craig Fugate**, Director, Division of Emergency Management, Florida Department of  
Community Affairs

**Richard Slevinski**, MD, Chair, Florida College of Emergency Physicians

**PROMOTING ACCESS AND AFFORDABILITY THROUGH CONSUMERISM**

404 House Office Building

**Ronald E. Bachman**, FSA, MAAA, President & Chief Executive Officer, Healthcare  
Visions, Inc. and Senior Fellow, Center for Health Transformation

**Christie Raniszewski Herrera**, Director, Health & Human Services Task Force,  
American Legislative Exchange Council

**Dale Brown**, Senior Vice President, MedImpact

**Randy Kammer**, Vice President of Regulatory Affairs & Public Policy, BC/BS of FL  
and President, The Blue Foundation for a Healthy Florida

**Lisa Rawlins**, Bureau Chief, Florida Agency for Health Care Administration



## DAVID MERRITT

David Merritt is a project director at the Center for Health Transformation. He leads the Health Information Technology, the Uninsured, HR Transformation and Consumer-Driven Healthcare projects at the Center. He also is active in member services, business development and client management. He works extensively with Congressional offices, the administration, the media, and private sector leaders to bring fundamental change to health and healthcare systems. His work has been published in the *Chicago Tribune*, *Miami Herald*, *Forward Magazine*, *Health Care Technology*, and on RealClearPolitics.com.

Prior to joining the Center, Mr. Merritt was with America's Health Insurance Plans (AHIP), the national trade association representing nearly 1,300 members providing health, long-term care, disability, dental and supplemental insurance to more than 200 million Americans. Mr. Merritt spent nearly five years directing the association's educational programs, with a primary focus on federal legislative and regulatory issues, including several advanced programs on HIPAA, HSAs, and the Medicare Modernization Act. Prior to joining AHIP, Mr. Merritt held several positions with the Washington Center for Internships and Academic Seminars, including managing the congressional internship program on Capitol Hill.

Mr. Merritt earned his master's degree in Political Science from Loyola University Chicago in 1999. He earned his bachelor's degree from Western Michigan University in 1996, where he studied public policy and communication and served as the opinion editor of the student newspaper.

Mr. Merritt lives in Alexandria, Virginia, with his wife, Kristin, and son, Charlie.



**Center for Health  
Transformation**

[www.healthtransformation.net](http://www.healthtransformation.net)

# ***Saving Lives and Saving Money:*** **Building a 21<sup>st</sup> Century Intelligent Health System**

David Merritt

Project Director

The Center for Health Transformation

[www.healthtransformation.net](http://www.healthtransformation.net)



# **21<sup>st</sup> Century Intelligent Health System**

**More Choices  
With Greater Quality  
At Lower Cost**



## **Current System**

**Provider-centered**

**Price-driven**

**45 million uninsured Americans**

**Slow diffusion of innovation and  
knowledge**

**Acute-focused**

**Paper-based**

**Third party controlled market**  
*(patient – provider – payor)*

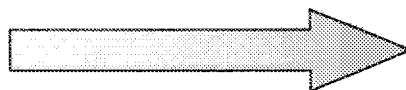
**Little information on cost and quality**

**Limited choice**

**Predatory trial lawyer litigation system**

**Overall cost increases**

**Care driven by volume and price**



## **21<sup>st</sup> Century System**

**Individual-centered**

**Values-driven**

**100% coverage**

**Rapid diffusion of innovation and  
knowledge**

**Prevention and health focused**

**Electronically based**

**Binary mediated market**  
*(individual – provider)*

**Right to know quality and cost info**

**Increased choice**

**New system of health justice**

**Overall cost decreases**

**Quality of care and quality of life**



# **Health Information Technology is the lever to transform health and healthcare**



**The goal of every stakeholder  
in healthcare must be the rapid  
and widespread adoption  
of consumer-centric health IT**

## **GERARD P. WHITE**

With more than 18 years of technology leadership experience, Gerard P. White guides the team responsible for successfully implementing the Clearwave Corporation vision and strategy. He co-founded the company in 2004 to carry out his own vision of technology that would span the healthcare continuum by encompassing the needs of patients, providers and carriers alike.

White brings to Clearwave extensive experience working with some of the most respected companies in the world including EDS, Security Mutual, Saturn, Lennox Industries, Continental Airlines, GTE, Alltel, Hitachi, Grant Thornton and Blue Cross Blue Shield. Both his knowledge and leadership experience provide a solid groundwork for Clearwave Corporation's active role in revolutionizing the healthcare industry.

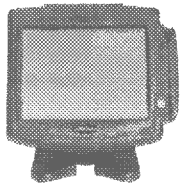
Prior to joining Clearwave, White was the CEO of 1stOrder, focusing on IT consulting services and wireless application development. He holds a Bachelor of Science degree in business management and a Bachelor of Applied Science degree in information systems.

# Center for Health Transformation

Quarterly Member Meeting

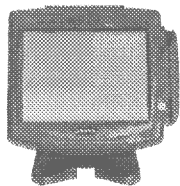
March 14, 2006

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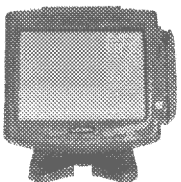
clearwave<sup>™</sup>

A picture is worth a  
thousand words!



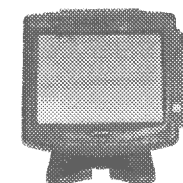
# What We Learned

- All payors (private and government)
- Must reduce costs and increase efficiencies for both payors and providers
- Self check-in process that creates a positive patient experience
- Self check-in process that starts with an electronic record
- Provide tools to patients that promote personal ownership of health and healthcare
- Low cost of entry to physicians



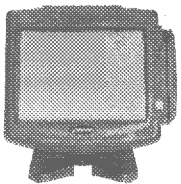
## Clearwave's Approach to Fraud, Waste and Abuse (FWA)

- Do not introduce solutions that are Payor specific
- Point of service device must be capable of working for all payors
  - United Track 2 magnetic stripe card
  - BCBS FL Track 3 magnetic stripe card
  - Texas Medicaid trialing fingerprint biometric
  - Other payors have no electronic card solution
- Do not address FWA by additional rules and regulations
- Utilize proven technologies
- Solution must include all players: employers, physicians, patients, payors



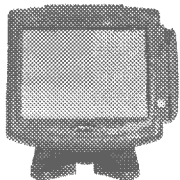
# Clearwave Solution

- Self service kiosk allows for multiple points of entry
  - RFID Card, Magnetic Stripe Card, Smart Card, Paper Card
  - Touch screen for manual entry (SSN)
- Physician and Member Portal (PHR)
- Clearwave's RFID card is most secure and expandable
  - RFID card, pin & biometric secure



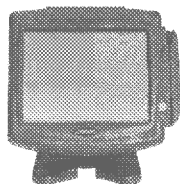
# Clearwave Functionality

- Real-time eligibility check
  - HIPAA compliant 270/271 transactions
- Personal Health Record
  - Eliminate need for paper-based check in on clipboard
- Payment Processing
  - Kiosk is a fully functioning credit card machine



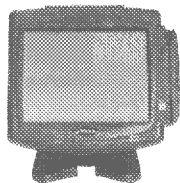
# All Payor System

- One access point by physician to payors
  - Allows the aggregation of data
  - Increases the number of real-time eligibility checks
    - ✓ Reduces rejected claims related to eligibility
    - ✓ Allows access to real-time remaining deductible
      - o Critical with HSA's - \$3000 to \$5000 deductibles
  - One user interface (data display) across payors
- All payor solutions in marketplace
  - Availity: Humana and BCBS of FL
  - Availity portal is widely used in Florida



# Clearwave Case Study

- Core Management Resource Group-Macon, GA  
(<http://www.coremrg.com/>)
  - Performed Health Risk Assessments
    - ✓ Blood work, health survey (online PHR), digital photo (RFID card)
- Clearwave manages Core's data:
  - Meadows Regional Hospital – Vidalia, GA
    - ✓ Approximately 1000 RFID cards
  - Dodge County Hospital – Eastman, GA
    - ✓ Approximately 500 RFID



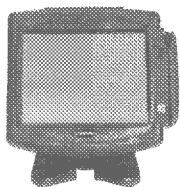
# Clearwave Case Study: Results

- Average response time for real-time eligibility check via Clearwave's Kiosk or Provider Portal (RFID card, pin & digital photo)

- Aetna: 7.18 seconds
- Cigna: 8.36 seconds
- GA Medicaid: 4.37 seconds
- United: 6.24 seconds
- Core Management Resources (via Clearwave):

**Sub 2 seconds**

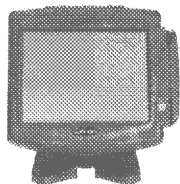
- Core & Clearwave will integrate PHR for download to physicians at the time of check-in
  - Rural GA PHR



# CitiGroup Smith Barney: Technology Key for Success

- Efficient, Real-time transaction processing & Capital to invest
  - ATM like real-time account balance, deposit, payment
- One Integrated Card: Medical, Rx, Specialty, HSA, Debit/Credit
  - User-Friendly Interfaces for Employers, Members, Providers
  - Savings account management, investment options
- Point of sale Technology
  - Important for consumer experience & provider profits
    - ✓ Bad debt only gets worse unless providers get connected
  - Pharmacy in the lead, already real-time, need SKU-recognition
  - Hospitals, MDs, other Providers have much work to do

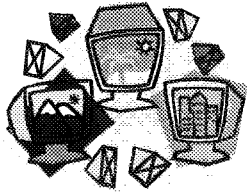
- Source: CitiGroup Investment Research, "Hello HSA, Goodbye HMO - The Birth of the HSA Should Spell the Death of HMOs"; Charles Boorady, Managing Director Smith Barney Equity Research



## **JOAN HOVHANESIAN**

Joan Hovhanesian is the Senior Vice President and Chief Information Officer of Shands HealthCare, affiliated with the University of Florida. Shands includes nine hospitals, more than 80 affiliated primary and specialty physician practices, and a medical staff of 1,500 UF faculty and community doctors. She is currently responsible for designing information technology strategy to support corporate strategies.

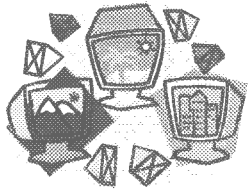
Ms. Hovhanesian has worked in the Health Information Technology industry for 30 years. Her background includes consulting, vendor sales and implementations of major applications. Consulting engagements have included multiple interim CIO roles, development of strategic plans for hospitals and health systems, and implementation of systems and strategies.



# ShandsHealthCare

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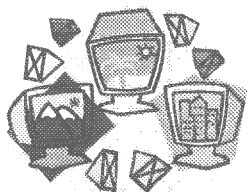
## **Roadmap to Clinical Computing**



# ShandsHealthCare

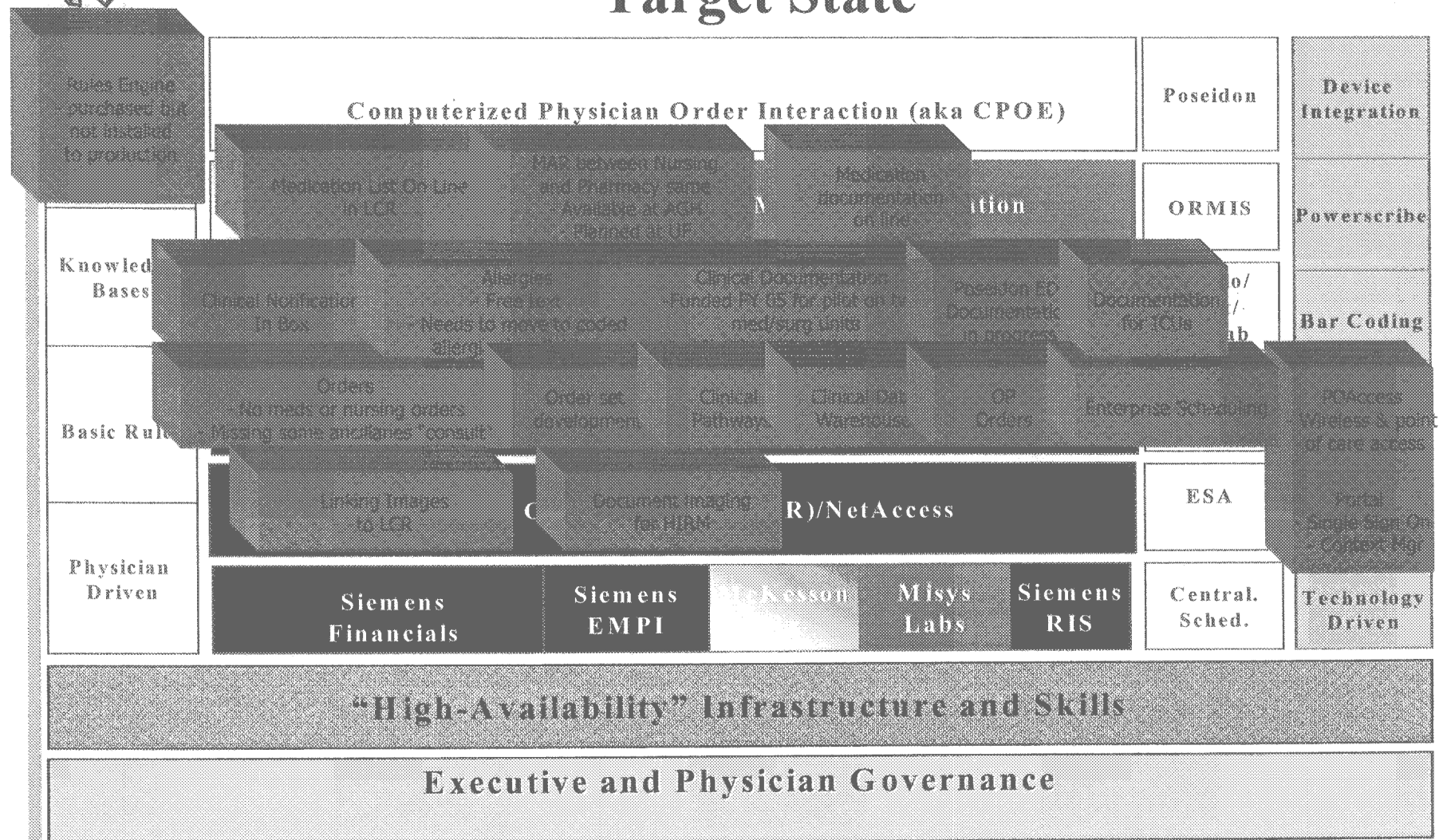
## “Target State”

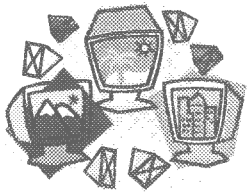
Expert Clinical Rules	Computerized Physician Order Interaction ( aka CPOE)				ED System	Device Integration
Knowledge Bases	Med Dispensing		Meds Administration		OR System	Voice Recognition Dictation
					Cardiac	Bar Coding
Basic Rules					PACs Imaging	Wireless Mobile Devices
					ESA	Portal for Single Sign On
Physician Driven				Labs	Central. Sched .	Technology Driven
“High-Availability” Infrastructure and Skills						
Executive and Physician Governance						



# ShandsHealthCare

## “Target State”





# ShandsHealthCare

SHANDS  
HealthCare

Physician's Orders

Patient Name:

MR#:

**Admission Orders for Community Acquired  
Pneumonia – ADULT page 1 of 3**  
(All orders with a ☐ must be checked to be activated)

1. Admit to: ☐ 74 MS ☐ Other \_\_\_\_\_
2. Service: \_\_\_\_\_, Dr. \_\_\_\_\_ attending, pager # \_\_\_\_\_  
Dr. \_\_\_\_\_ resident/intern, pager # \_\_\_\_\_
3. Diagnosis: Community Acquired Pneumonia
4. Allergies: (Substance/Reaction)
5. Vital Signs: ☐ q4hr ☐ q4hr x 48; then q shift
6. Precautions: Aspiration
7. Labs: If not done in ED or admission site; send the following labs:
  - ☒ Pretreatment blood cultures x 2 (different sites) **DO NOT** delay starting antibiotics
  - ☐ Basic metabolic Panel
  - ☐ CBC with Diff
  - ☐ Sputum for gram stain and culture
  - ☐ Other labs \_\_\_\_\_
8. Radiology: Chest X-ray if not done in ED
  - ☐ AP/Lateral Chest X-ray: Evaluate for infiltrate
  - ☐ Portable Chest X-ray: Evaluate for infiltrate
9. Isolation:  
Upper lobe infiltrate or cavity, HIV positive, or immunocompromised patients require respiratory isolations.
10. Diet:
  - ☐ Regular
  - ☐ Encourage PO fluids
  - ☐ Other \_\_\_\_\_
11. Activity:
  - ☐ Head of bed elevated to 30 degrees
  - ☐ Out of bed as tolerated
  - ☐ Other \_\_\_\_\_
12. IVF:
  - ☐ IVF: \_\_\_\_\_
  - ☐ Medlock IV

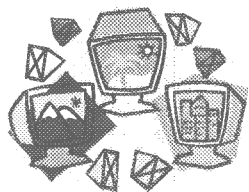
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10/14/03

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# ShandsHealthCare

SHANDS  
HealthCare

Physician's Orders

Patient Name:

MR#:

Date/Time

Admission Orders for Community  
Acquired Pneumonia -- ADULT page 2 of 3  
(All orders with a ☐ must be checked to be activated)

Clinical  
Documentation - Any

ICU  
Documentation

Allergies

Drug to Drug  
Interaction

Rules Engine

Meds in LCR

13. Respiratory:

- ☐ O<sub>2</sub> sat check with VS
- ☐ Pulse Ox (continuous)
- ☐ O<sub>2</sub> \_\_\_\_\_ per NC/face mask; may wean O<sub>2</sub> as tolerated (maintain SaO<sub>2</sub> greater than 92%)
- ☐ albuterol MDI with spacer; 2 puffs every 6hr and PRN; wheezing
- ☐ ipratropium (ATROVENT) MDI with spacer; 2 puffs every 6hr and PRN wheezing
- ☐ Please instruct patient in use of inhaler with spacer

14. Medications: Antibiotics

- ☐ Option 1  
Ceftriaxone (ROCEPHIN) 1 g IV q24hr for 2 days then cefuroxime 500 mg PO BID  
AND azithromycin (ZITHROMAX) 500 mg PO for 1 dose; then 250 mg PO daily for 4 days

- ☐ Options 2  
Gatifloxacin (TEQUIN) 400 mg IV q24hr for 2 doses; then 400 mg PO daily

Adjust gatifloxacin (TEQUIN) for renal dysfunction. Patients with a CrCl of \_\_\_\_\_  
mL/min should receive 400 mg on Day 1, then 200 mg every day, thereafter

- ☐ gatifloxacin (TEQUIN) adjustment: \_\_\_\_\_
- ☐ acetaminophen (TYLENOL) 650 mg PO q4hr PRN pain or Temp greater than 38.5° C (NOT TO EXCEED 4g per day)

Other Antibiotic: \_\_\_\_\_ Indication: \_\_\_\_\_

15. DVT Prophylaxis:

- ☐ A) heparin 5,000 mg subcutaneous every 12 hr
- ☐ B) enoxaparin (LOVENOX) 40 mg daily
- ☐ C) SCDs at all times
- ☐ D) Other \_\_\_\_\_

16. Other Medications:

- ☐
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐

Clinical  
Documentation

Medication  
Documentation  
on Line

Rules to Check Labs

Medication  
Documentation  
on Line

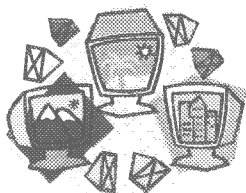
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10/14/03

PS32775-1003

3/10/2006

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# ShandsHealthCare

SHANDS  
HealthCare

Physician's Orders

Patient Name:

MR#:

Date/Time

Admission Orders for Community Acquired

Pneumonia -- ADULT *page 3 of 3*

(All orders with a ☐ must be checked to be activated)

17. Vaccines:

- ☐ influenza vaccine 0.5 mL IM for 1 dose, on day of discharge (Oct-Jan); document on IPFER  
☐ pneumococcal vaccine (PNEUMOVAX) 9.5 mL IM for 1 dose, on day of discharge; document on IPFER

18. Provide smoking cessation information, if patient smokes; document on IPFER

19. Consults:

☐ PT Indication: \_\_\_\_\_

☐ OT Indication: \_\_\_\_\_

☐ Pharmacokinetics Indication: \_\_\_\_\_

☐ Other \_\_\_\_\_ Indication: \_\_\_\_\_

20. Call House Officer for: Respiratory distress, O<sub>2</sub> sats less than 92%, RR greater than 20, Temp greater than 38.5° C, SBP less than 90 or greater than 180 mm Hg, HR less than 50 or greater than 120.

Clinical  
Documentation

Orders -  
Nursing

Clinical Data  
Warehouse

Medical Record  
Imaging

MD Signature \_\_\_\_\_ MD# \_\_\_\_\_ Pager # \_\_\_\_\_

Orders Transcribed by \_\_\_\_\_ Date/Time \_\_\_\_\_

Orders Verified \_\_\_\_\_ Date/Time \_\_\_\_\_

Attention: Medical Record - Be sure to fax to Pharmacy.  
03

PS32775-1003

3/10/2006

## **DR. TIMOTHY J. YEATMAN**

Dr. Timothy J. Yeatman, F.A.C.S., is the Associate Center Director for Translational Research and Director of Total Cancer Care at H. Lee Moffitt Cancer Center and Research Institute. In this role, he has responsibility for developing translational research at Moffitt by leading the infrastructure development and implementation of Total Cancer Care (TCC). The successful implementation of TCC involves collaborations with many areas of the Cancer Center such as information technology, health outcomes and behavior, and the expansion of tumor banking, tissue microarray, and gene expression profiling capabilities. In addition, Dr. Yeatman, working with Adil Daud, M.D., oversees the Affiliate Research Program and continued expansion of translational research trials at Moffitt affiliate sites throughout the state. He joined the Moffitt Cancer Center in 1992.

Dr. Yeatman has focused his research on the management of gastrointestinal malignancies with a special research emphasis on using genome scale microarrays to identify the molecular signatures of cancer that provide diagnosis, prognosis and response to therapy. He recently compared microarray data of 540 human tumors of 21 different tumor types with the diagnoses obtained from tumor biopsies. He found that microarray was 88 percent accurate in predicting all tumor types. The results of his investigation, the first such work to be reported in this depth, appeared in the January 2004 issue of the *American Journal of Pathology*. In addition, he and his colleagues have detected 340 new tumor markers and more than 100 tumor progression markers whose expression correlated with progressing tumor stage. Some of these markers may be useful in the clinical management of colon cancer patients because of their capacity to detect and predict the stage of cancer.

He has published more than 115 articles in the top peer-reviewed journals in his field including the prestigious *Nature Genetics*, *Nature Reviews Cancer*, as well as the *Journal of the National Cancer Institute*, and *Cancer Research*. He has received numerous honors and awards including the James IV Association of Surgeons Traveling Fellowship, Europe 2001; the Center Director's Award for Outstanding Research at Moffitt Cancer Center (1998, 1997, 1995); and the James Ewing Foundation Trainee Award, Society of Surgical Oncology, 1997.

# TOTAL CANCER CARE CONSORTIUM

*“Discover, Translate, Deliver Personalized  
Cancer Care”*

**Timothy J. Yeatman, M.D., FACS**  
**Professor of Surgery & Interdisciplinary**  
**Oncology**  
**Associate Center Director**  
**for Translational Research**  
**Director, TCC**  
**H. LEE MOFFITT CANCER CENTER**

# **The Problem with Contemporary Cancer Care**

- Many patients are treated to help an unknown few—one size fits all
- Drug therapy is generally not tailored to the patient
- Response rates low, toxicity high
- Patients do not want to leave home for treatment

## **The Solution:**

**Total Cancer Care Consortium: a  
Statewide Enterprise Effort  
(Academic + Community)**

A research project that will  
lead to *personalized* cancer  
care by 2010



Research



Practice

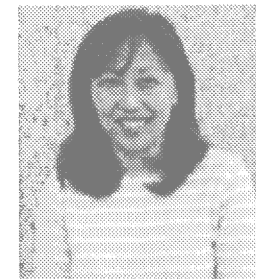
Total Cancer Care

Personalized Cancer Care

**2010**



*Study large populations...*



*Develop therapies for  
Subpopulations of individuals...*

# What is TCC?

- Perhaps the worlds largest translational research project
- A means to collect, relate, and interpret clinical data and molecular data from thousands of patients across Florida
  - Tumor and blood samples
  - Clinical data (risk factors, therapies, responses, survival)
- A mechanism to identify molecular signatures for diagnosis, prognosis, and prediction of response to therapy
- A means to personalize cancer therapy by matching “pipeline” drugs to patients harboring molecular targets
- A means to improve the quality of medicine

# Hypothesis/Plan

- Identify drug-specific molecular targets (or surrogate for it)
- Determine prevalence of targets in large Florida database
- Enrich pipeline drug trials with Florida patients harboring the target
- Engage and invest in community and academic partners to achieve necessary accrual
- Decrease time to drug registration

# Key Elements of TCC

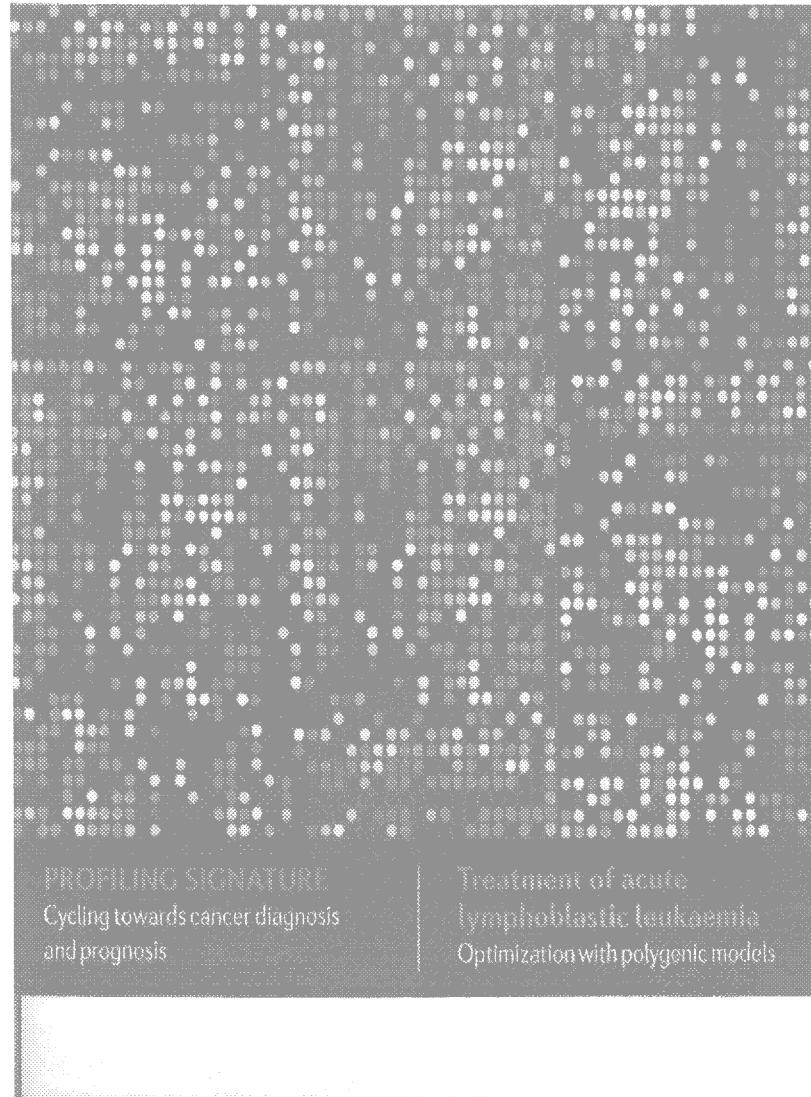
- All cancer patients consent to a lifetime research project
- Tissues and Genetic Signatures
- Trials and Pipeline Drugs
- Quality Improvement and EBM
- Investment of personnel & technology
- Partnerships with patients, physicians, academia, community, biotech, big pharma: “enterprise” effort

# nature REVIEWS

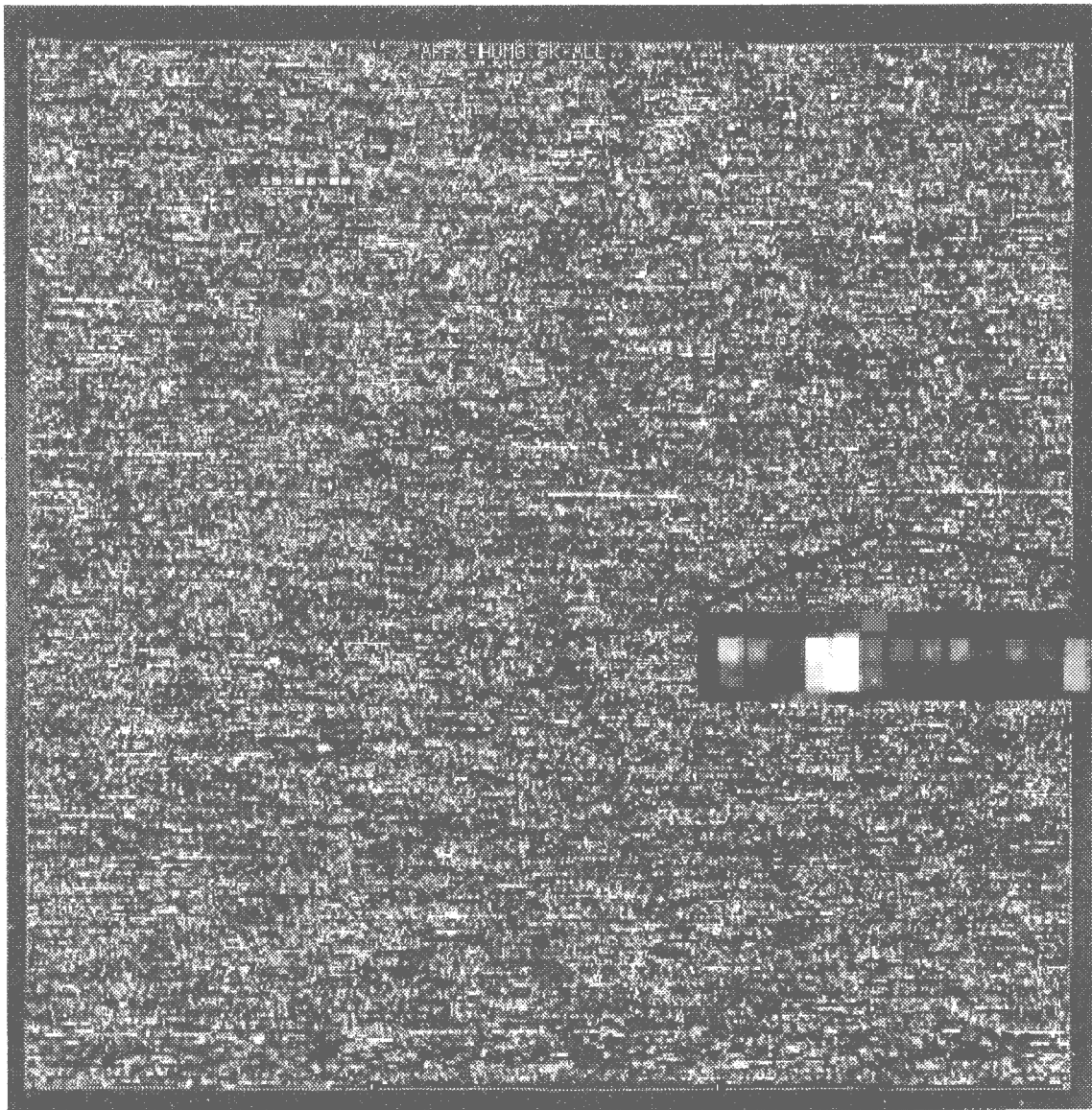
february 2006 volume 6 no. 2  
[www.nature.com/reviews](http://www.nature.com/reviews)

 Biomarkers  
FOCUS

## CANCER

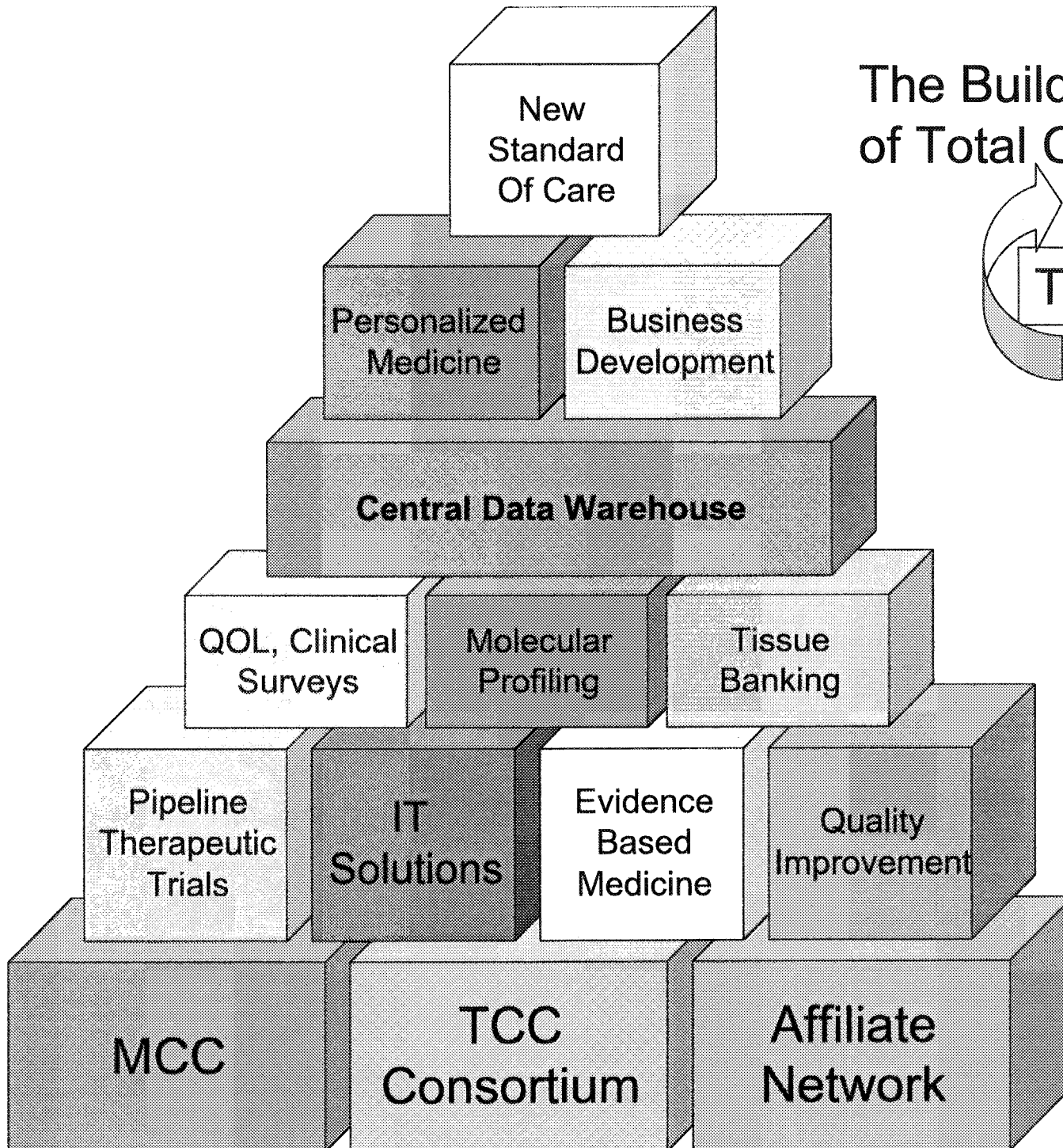


# Affymetrix Discovery Platform

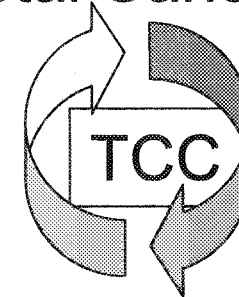


52K elements  
Whole Genome





## The Building Blocks of Total Cancer Care



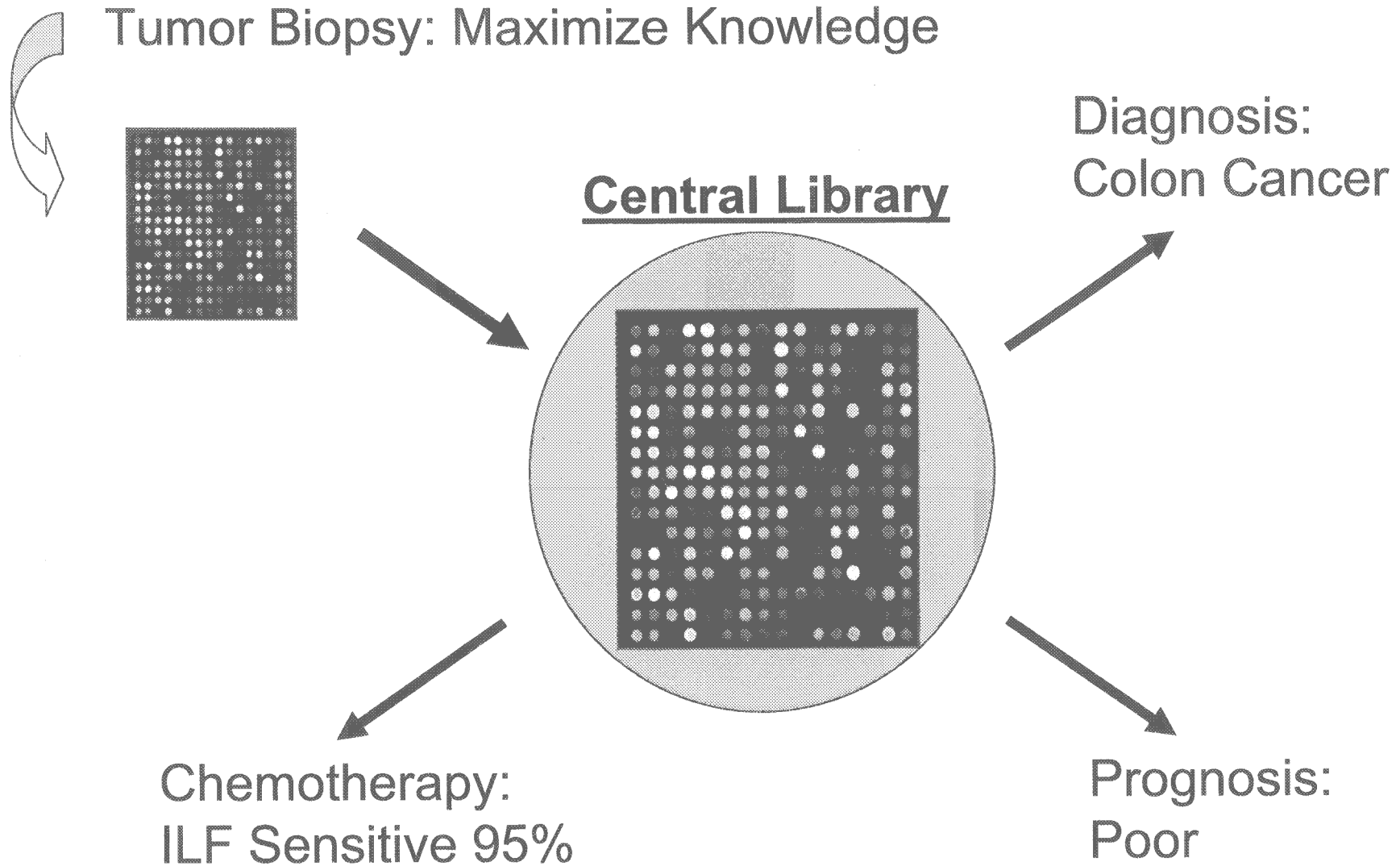
# Promise of TCC Approach

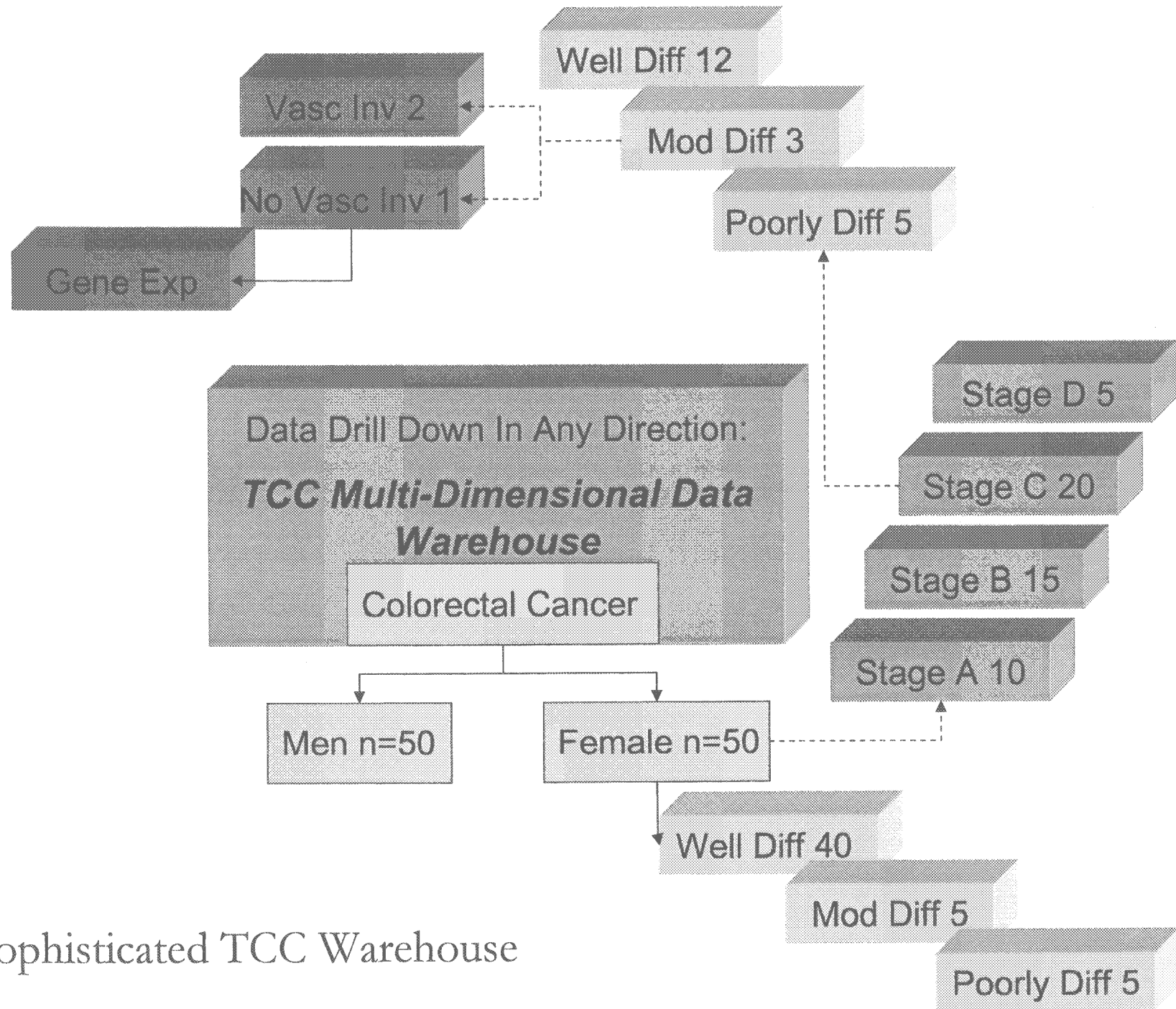
- Old Approach:
  - New Phase II drug
  - Patients randomly selected from trial
  - Hope for 3 responses out of 30 pts
- New Approach:
  - New Phase II drug—identify target
  - Identify patients harboring target in TCC database
  - Accrue 30 pts harboring target
  - Potential to speed and enhance drug registration

**5 Years in the Future**

**One Tumor, One Chip™**

# Vision for Future





Sophisticated TCC Warehouse

# Three Portals to Data

Patient View

Clinician View

Researcher View

*TCC Multi-Dimensional Data  
Warehouse*

Clinical Data  
(summarized)

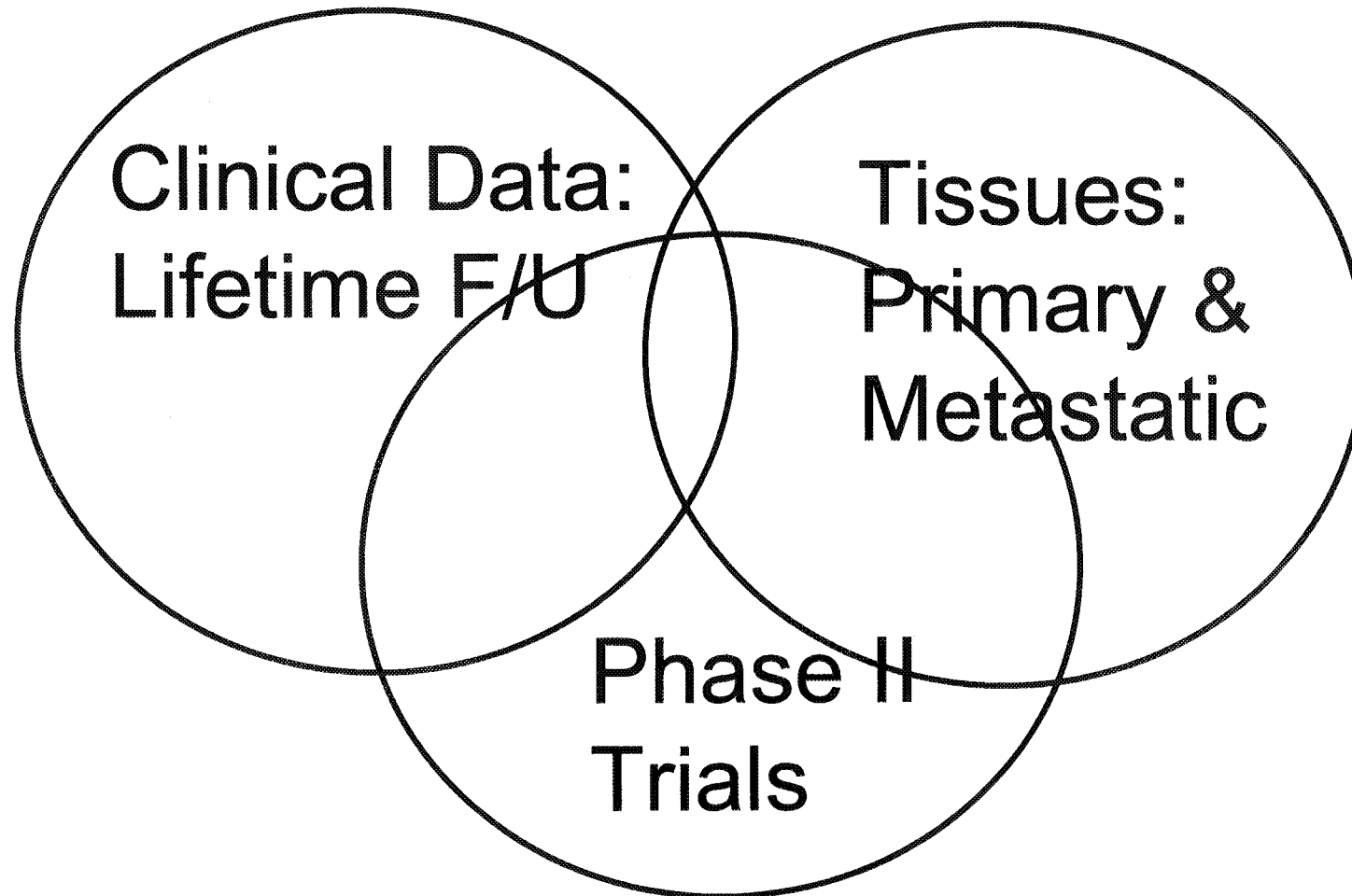
Clinical Data  
Dicom Archive

Gene Expression  
Clinical Data

# Touch Screen Technology



# No One Has Done It Right



100% Electronic  
Web Enabled

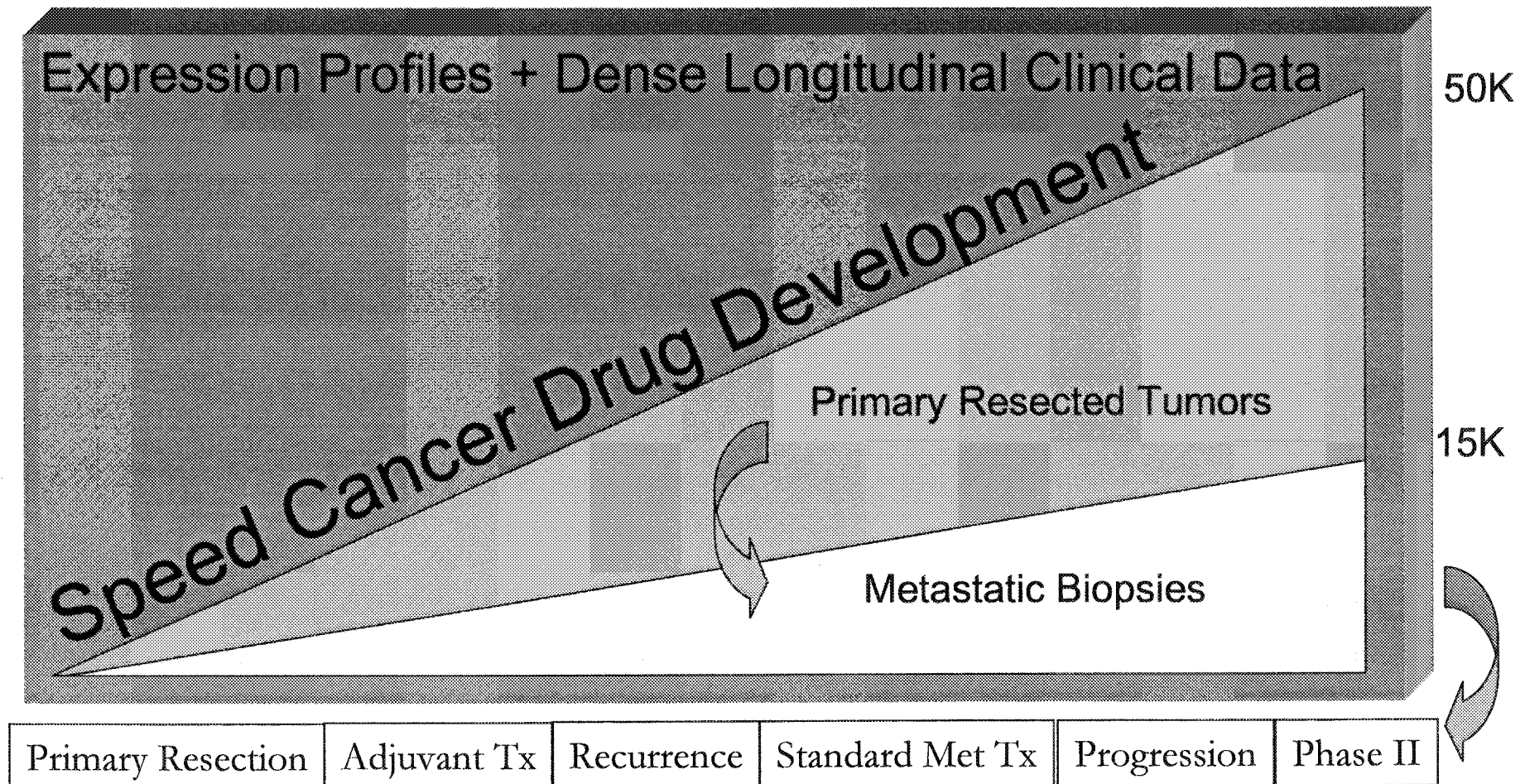
# Phases

- Phase I (Underway)
  - Demonstrate TCC clinical data and tissue/blood can be collected from MCC and 3 community affiliate hospitals
  - Introduce and test touch screen tablet PC system
- Phase II (Summer 2006)
  - Develop formal TCC consortium
  - Initiate TCC protocol at ~ 8 sites
  - Expand to collect metastatic biopsies (interventional radiology)
  - Initiate multiple Phase II trials
  - Enrich trials with patients harboring appropriate targets

# The World's Largest Biorepository and Data Warehouse

2006

2010



# TCC Consortium 5-Yr Goals

- Collect, process, and array 50,000 primary tumors & 15,000 metastatic tumors in 5 years
- Co-opt community and academic centers statewide
- Establish multi-dimensional gene expression database with deep clinical annotation: 65,000 tumors x 54,000 genes x 500 clinical endpoints
- Initiate and accrue to 10 or more Phase II pipeline trials enriched with patients harboring targets
- Develop molecular signatures for diagnosis, prognosis, and response to therapy
- Establish THE validation test set for cancer
- Identify new business interests in vast data set

# Moon Shot Spin-offs of TCC

- New Investments in State
  - Big Pharma (realized)
  - Biotech (realized)
  - Information Technology linking hospitals and physicians
- Improved Standard of Medical Care
  - Technology advances
  - State of the art clinical trials delivered to community
- Evidence Based Medicine/ Quality Improvement
- Decrease time to new drug registration
- “Resurrection” of shelved therapeutics
- Potential for Reduced Health Care Costs
  - Target therapies to “right patients at the right time”
  - Molecular tests may reduce need for surgical staging
- TCC models extendable to other diseases

# **Biotech Boom in Tampa**

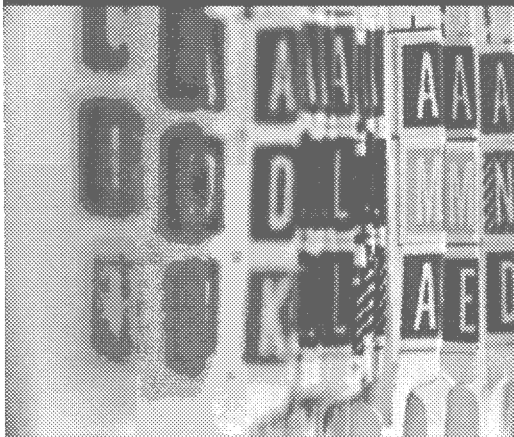
- Brand new incubator space on Moffitt/USF campus
- Burgeoning opportunity for biotech development linked to TCC Data Warehouse
  - Informatics
  - Computer science
  - Genomics
  - Proteomics

## **W. MICHAEL HEEKIN**

W. Michael Heekin currently serves as Chair of the Florida Governor's Health Information Infrastructure Advisory Board. He was a founding board member and the first chief operating officer of WebMD. Mr. Heekin played a leading role in the transformation of the company from a provider of transtelephonic heart-monitoring services to the industry leader in Internet-based health informatics and information technology. He structured and managed strategic relationships with such partners as Microsoft, Medtronic, News Corporation, Cable News Network, E.I. du Pont de Nemours and Company and Softbank. At WebMD, Michael also organized and launched WebMD International, a global joint venture between News Corporation and WebMD; including the launch of WebMD Canada and WebMD UK Health.

Earlier in his career, Mr. Heekin served in various positions including Senior Vice President, General Counsel and Corporate Secretary of American Heritage Life Insurance Company in Jacksonville, Receiver of Guarantee Security Life Insurance Company, appointed by the Treasurer of the State of Florida, Associate Dean of the Florida State University College of Law, and Captain in the United States Army.

He serves on the Executive Board of the Boy Scouts' Atlanta Area Council, the Executive Advisory Board of the H. Lee Moffitt Cancer Center Total Cancer Care initiative, and the Board of Trustees of the University of Florida Law Center Association. He earned a Master of Business Administration at the Wharton School of the University of Pennsylvania, and law and accounting degrees from the University of Florida.



#2

THE ACTIVE PARTICIPANT

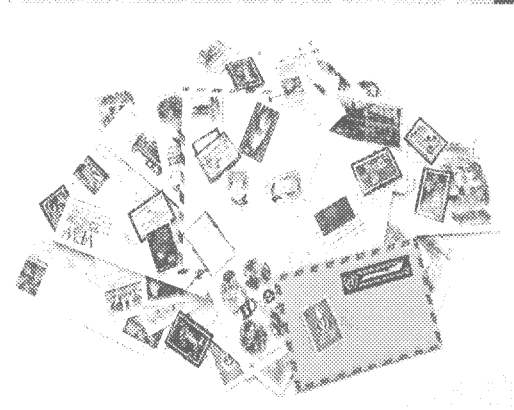
FOR ANTIHISTORIC OBJECTS CHECK THE APPROPRIATE BOX

☐ HISTORICAL PREVIOUS ☐ PRESENT ☐ NEW SURVEY

4/10/10 10:00 AM -  
4/10/10 10:00 AM  
4/10/10 10:00 AM  
4/10/10 10:00 AM

LOCATION OF OBJECTS

M.D.

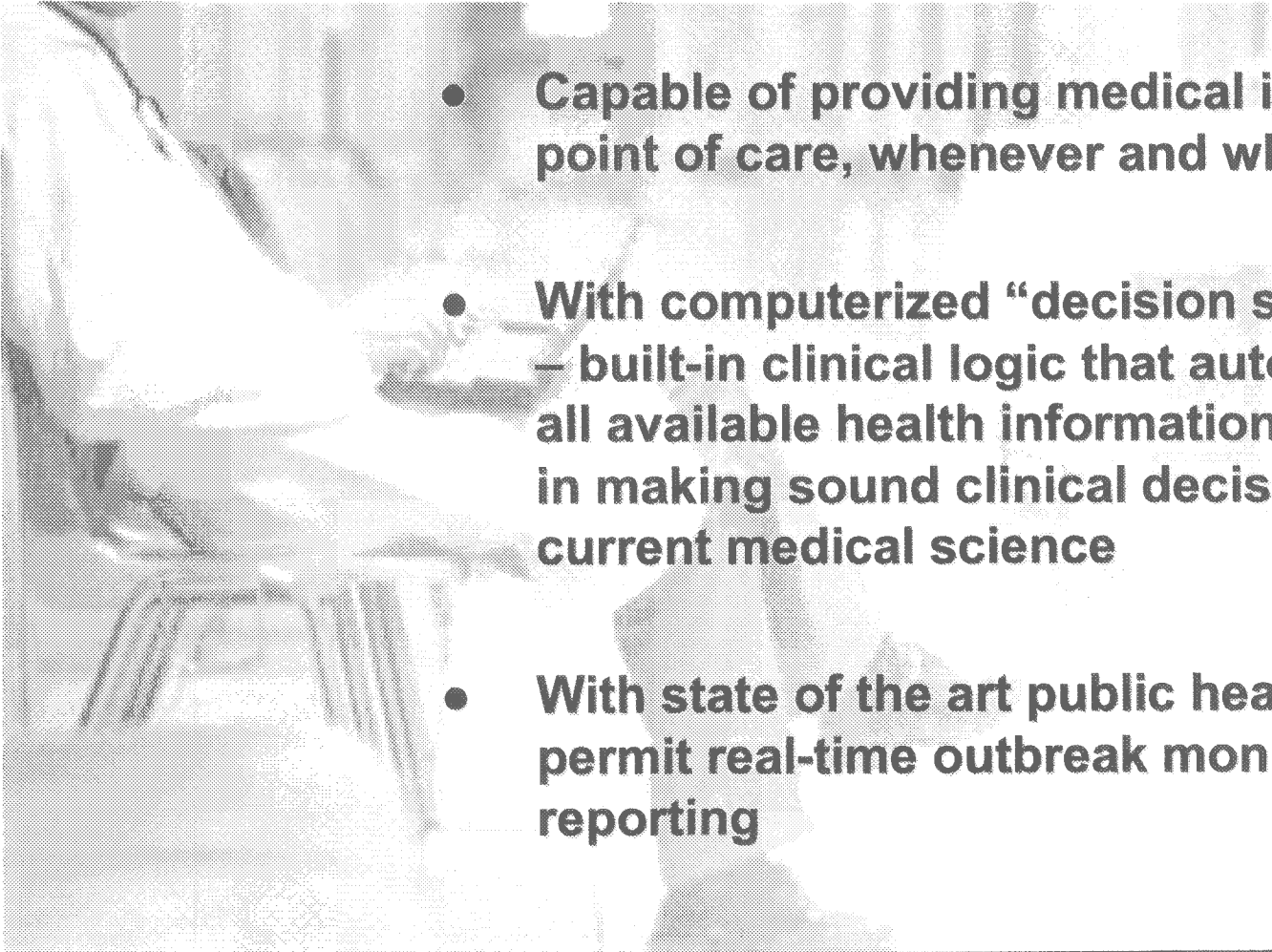


# The Florida Health Information Network – a Progress Report



# The Vision:

– a comprehensive integrated network of health record systems among the state's healthcare stakeholders

- 
- **Capable of providing medical information at the point of care, whenever and wherever that may be**
  - **With computerized “decision support” programs**
    - **built-in clinical logic that automatically analyzes all available health information to assist providers in making sound clinical decisions based on current medical science**
  - **With state of the art public health functionality to permit real-time outbreak monitoring and disease reporting**

# The Governor's Health Information Infrastructure Advisory Board

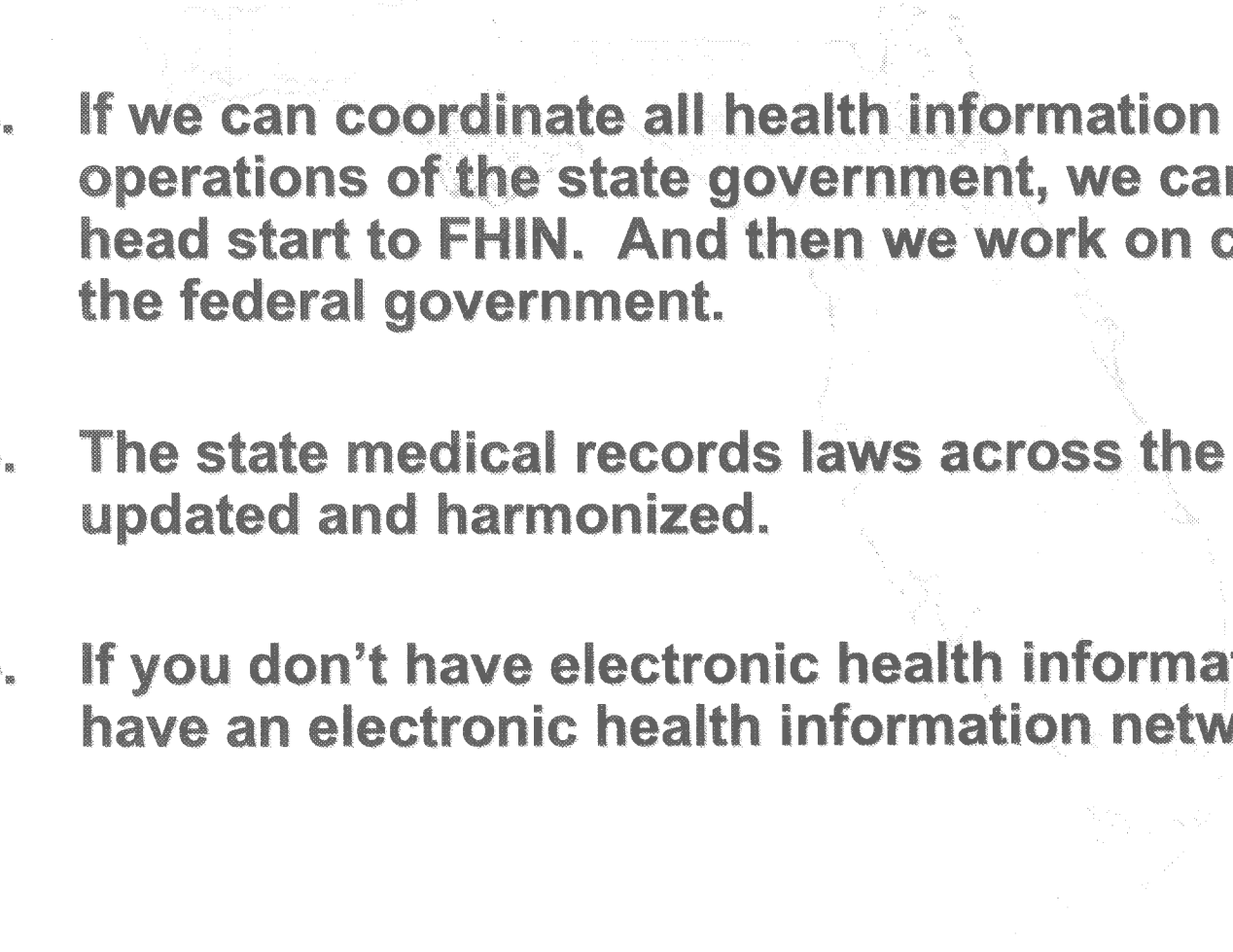
- **Appointed by Governor Jeb Bush in June 2004**
- **Mission:**
  - **Advise Governor and Agency for Healthcare Administration on the development of the Florida Health Information Network – “FHIN”**
  - **Identify obstacles to the implementation of FHIN and provide policy recommendations to remove or minimize those obstacles**
  - **Assist in ensuring the privacy and security of personal health information on the network**



## **A few observations after a year and a half on the job . . . .**

- 1. Stakeholders in state are generally supportive of the Florida Health Information Network, but that support has not been “stress tested” yet; i.e., few pocketbook issues encountered to date.**
- 2. The challenges we face are not so much technical as “human” – establishment of trust, resistance to change, governance structure, financial considerations, cooperation with competitors, legal . . . .**
- 3. Planning the network will not bear any more study – time to launch and learn.**

**. . . and a few more . . .**

- 
- 4. If we can coordinate all health information initiatives and operations of the state government, we can provide a real head start to FHIN. And then we work on coordinating with the federal government.**
  - 5. The state medical records laws across the nation need to be updated and harmonized.**
  - 6. If you don't have electronic health information, you can't have an electronic health information network.**

In an environment of low EHR usage, claims forms contain valuable electronic health information that is available to be shared

HCFA 1500 (Doctor's Claim Form):

The image shows the HCFA 1500 (Doctor's Claim Form), which is a standard form for medical claims. It is divided into several sections: 1. Patient Information (Name, Address, Date of Birth, Sex, Race, Ethnicity, etc.), 2. Insurance Information (Type of Insurance, Policy Number, etc.), 3. Health Insurance Claim Form (Diagnosis, Procedures, etc.), 4. Referring Physician Information (Name, Address, etc.), 5. Treating Physician Information (Name, Address, etc.), 6. Billing Information (Date of Service, Place of Service, etc.), 7. Medications (List of Medications, Dosage, etc.), 8. Lab Values (List of Lab Tests, Results, etc.). The form is filled out with handwritten information, and arrows point from the form to the text labels on the right.

Patient Demographic info

Date of treatment

Diagnosis

Procedures

Identities of treating and referring providers and contact information

(Medications)

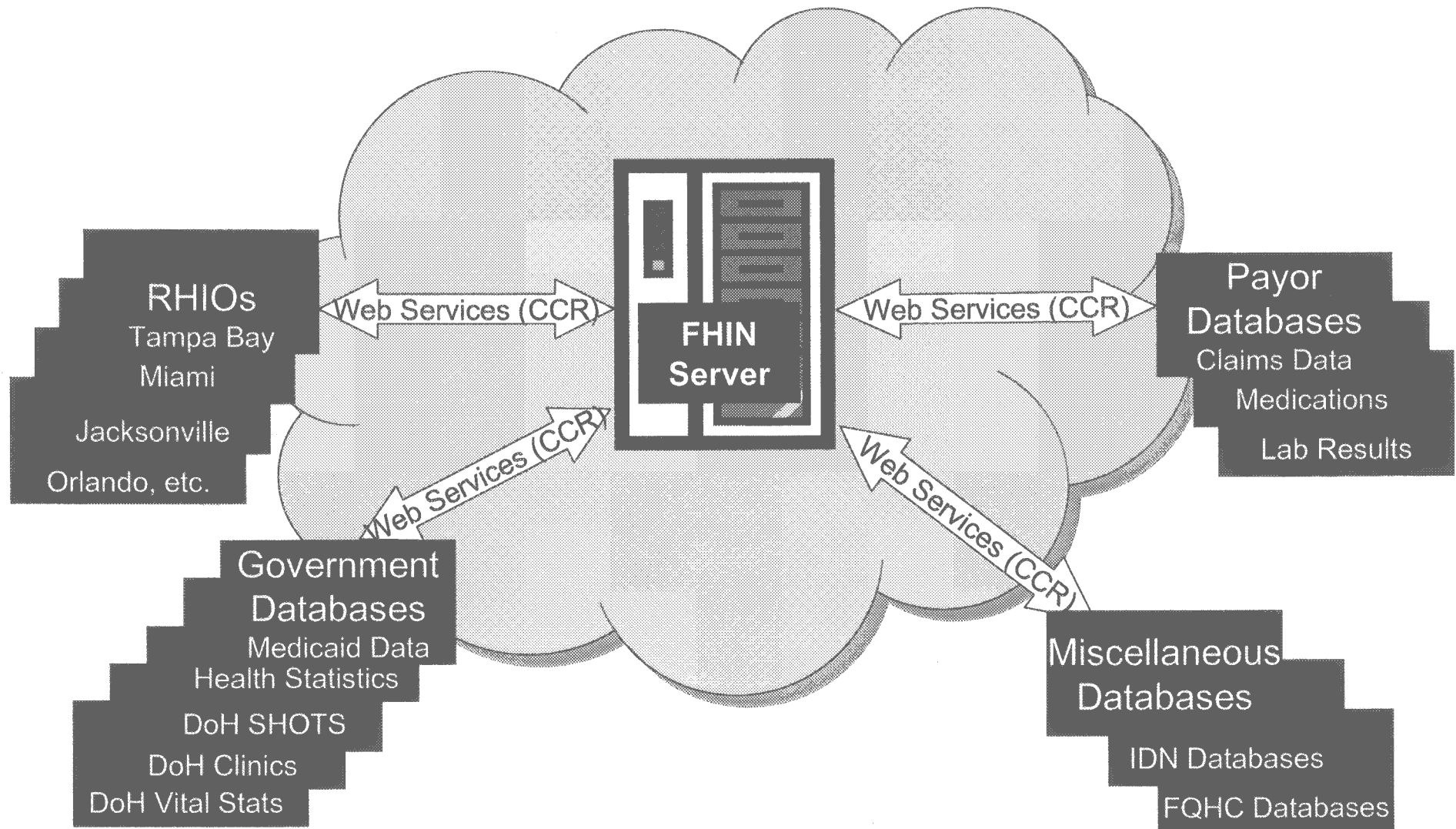
(Lab values)

UB 92 (Hospital's Claim Form):

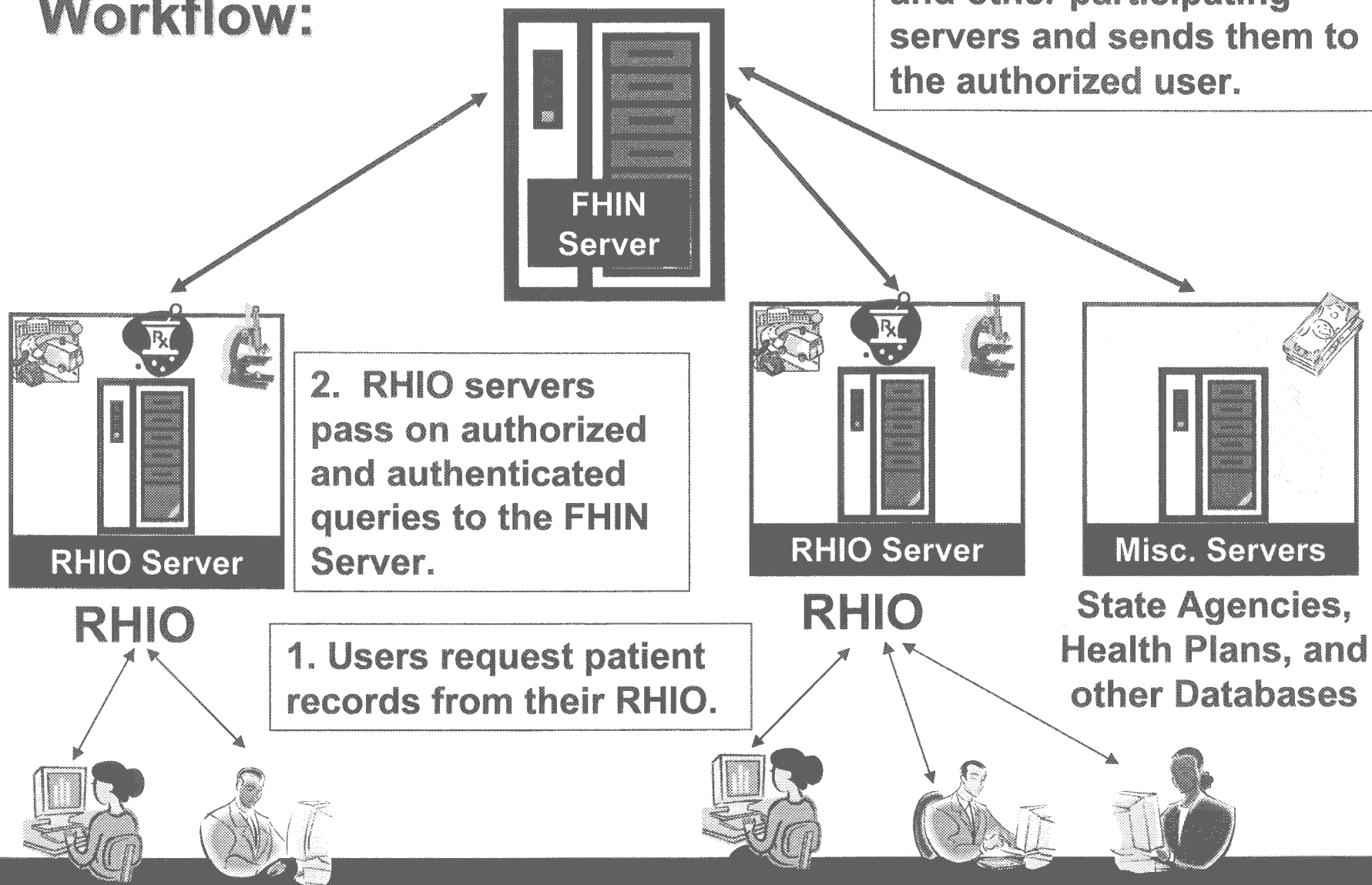
The image shows the UB 92 (Hospital's Claim Form), which is a standard form for hospital claims. It is divided into several sections: 1. Patient Information (Name, Address, Date of Birth, Sex, Race, Ethnicity, etc.), 2. Insurance Information (Type of Insurance, Policy Number, etc.), 3. Health Insurance Claim Form (Diagnosis, Procedures, etc.), 4. Referring Physician Information (Name, Address, etc.), 5. Treating Physician Information (Name, Address, etc.), 6. Billing Information (Date of Service, Place of Service, etc.), 7. Medications (List of Medications, Dosage, etc.), 8. Lab Values (List of Lab Tests, Results, etc.). The form is filled out with handwritten information, and arrows point from the form to the text labels on the left.

# Florida Health Information Network

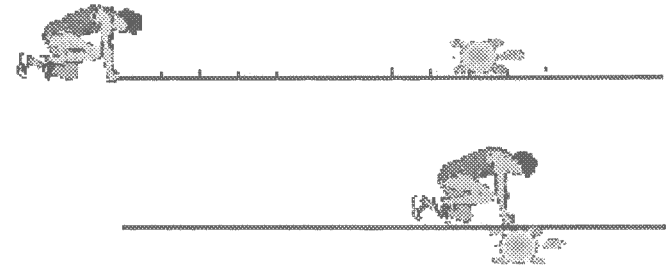
## Statewide Architecture



# Potential Workflow:




## Zeno of Elea, circa 450 B.C., on Building the Florida Health Information Network



Zeno's Paradox: When running a race, the runner must first traverse half the distance. Then, he must cover half of the remaining distance. Yet again, he must cover half of that remaining distance . . . and so on forever. Therefore, it is impossible to finish the course.

In plain English: There are a hundred reasons why it will not work. Let's get going and handle them one at a time.



**The things that are urgent are seldom important, and the things that are important are seldom urgent.**

– General Dwight D. Eisenhower

## ROBERT EGGE

Robert Egge is a project director at the Center for Health Transformation. In this position he leads key projects foundational to health transformation, including the Health Preparedness and Homeland Security, Accelerating Health Innovation and the Right to Know initiatives. Mr. Egge is also involved in client management and business development for the Center.

Prior to joining the Center for Health Transformation, Mr. Egge was Vice President for Public Affairs at the JC Watts Companies (JCWC). In this capacity he advised and represented JCWC's government affairs clients from healthcare and other heavily regulated industries. While with JCWC, Mr. Egge served as an associate faculty member with George Mason University.

Mr. Egge was also Director of Operations at Marvin Zonis and Associates (MZA), an international government affairs and regulatory policy consulting firm. While with MZA, he directed policy analysis and government relations engagements for a range of leading international corporations.

He has been published in *The New York Times*, *Financial Times' Mastering Management Review* and *International Political Economy*. He has also written a text used in graduate courses on policy analysis. Mr. Egge graduated magna cum laude from Wheaton College (IL). He is currently completing his doctoral dissertation on healthcare policy at the University of Chicago's Harris School of Public Policy. He lives in Falls Church, Virginia with his wife, Leslie, and their son and daughter.

# **The Center for Health Transformation Preparing for Pandemic Influenza**

# **Risks of pandemic influenza: Significant and unprecedented**

- Range of opinions among scientific experts, but even “skeptics” urge preparation
- Progression is unprecedented; epidemiological implications are uncertain
- Dimensions of uncertainty:
  - Timing
  - Transmissibility
  - Virulence
  - Societal impact and response

# **Florida's risk profile: Distinct strengths and challenges**

- Strengths include:
  - Crisis / emergency management expertise
  - Health information technology investments
  - Innovations from FL Department of Public Health
- Challenges include:
  - Demographics
  - Industry profile

## **Policy dilemma: Balancing investments in short-term and long-term strategies**

- Short-term strategies focus on attaining and then sustaining a defined threshold
  - Stockpiling available therapies
  - Developing communications and continuity plans
- Long-term strategies focus on breakthroughs
  - Information-rich medical control capabilities
  - 21<sup>st</sup> century public health system
  - Developing diagnostics and therapies

## **Challenge: sustaining preparations throughout the “phony war” period**

- It's very difficult to sustain a crisis footing, **So** –
- Focus on dual-use capabilities, which provide:
  - Benefits, whether or not there's a pandemic
  - (And, therefore) A sustainable appropriations path
  - Familiarity with use when a crisis hits

## **Key dual-use strategies:**

- An intelligent, interconnected health system
  - Real-time intelligence
  - More robust response options
- A 21<sup>st</sup> century public health service
  - A force-multiplier approach
  - Harness private sector capabilities
- Next-generation therapies and diagnostics
  - Perhaps warranted to encourage development in FL
  - Regardless, send strong signal to Washington, DC

## Conclusions

- Pandemic influenza poses a significant risk; robust preparations are warranted
- Short-term focus: detailed, stress-tested continuity planning with private sector included
- Long-term focus: carefully crafted dual-use strategies that can “change the game”

## **DR. M. RONY FRANÇOIS**

M. Rony François, M.D., M.S.P.H., Ph.D. was appointed by Governor Bush as the Secretary of the Florida Department of Health on September 15, 2005.

The first Haitian American to lead the Department, Dr. François was born in Port-au-Prince, Haiti. He immigrated to the United States 26 years ago to attend Tallahassee Community College, earning an associate degree in one year. Later transferring to the University of Central Florida (UCF) he obtained a Masters of Art degree in Exercise Physiology.

Dr. Francois played professional soccer with the Orlando Lions while working as an exercise physiologist and adjunct math teacher at Valencia Community College.

Dr. François served as a medical program volunteer at the Judeo-Christian Clinic for the Indigent for three years while working on his medical degree, which he received in 1994. He served his first residency in obstetrics and gynecology at Arnold Palmer Hospital in Orlando. He earned his Masters of Science degree in public health in 1998, then enrolled at the University of South Florida (USF) toxicology doctoral program. He completed his Doctor of Philosophy in toxicology/public health degree in August 2003.

The Secretary served a second residency in occupational medicine at USF and began his medical career at Tampa General Hospital as an occupational medicine physician from 1997-1999. From 1998 until his appointment as Secretary of Health, Dr. François also served as the CHD Meridian Medical Director at the Citibank Center in Tampa, was Director of the USF Public Health Practice Program, and an Assistant Professor at the USF College of Public Health, where his research focus was on tracking data to assess the potential link between the environment and disease.

Dr. François served on the United States Environmental Protection Agency's Federal Insecticide, Fungicide, and Rodenticide Act Scientific Advisory Board for the Health Hazards of Copper Chromium Arsenate on Children, as well as a member of the Florida Department of Health's Arsenic Working Group for the Health Hazards of Copper Chromium Arsenate on Children. In early 2005, Dr. François was presented the Outstanding Leadership by Faculty Advisor award at USF and was inducted into the UCF Athletics Hall of Fame.

Dr. François has a wife, Joelle, and three children, Rony Andre, Patrick George, and Joelle Anne.



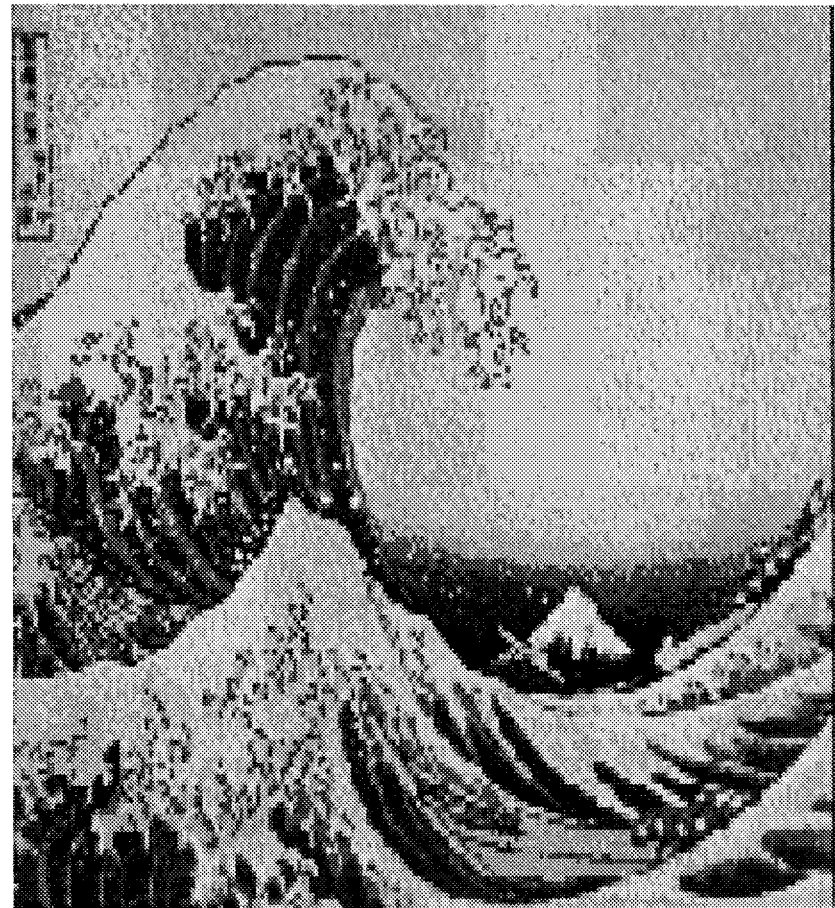
# **Avian Influenza: The Next Pandemic?**

**Florida Department of Health  
2006**

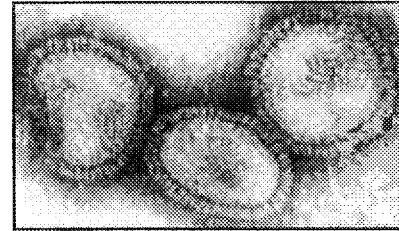
**M. Rony François, M.D., M.S.P.H., Ph.D.**

***Avian influenza is becoming “the perfect storm” ... a storm created by so rare a combination of factors that it could not possibly be worse ...***

***The Perfect Storm***  
**Sebastian Junger**



# Etiology



- Viral disease, member of *Orthomyxoviridae*
  - Highly infectious type A virus
  - Incubates rapidly
- Subtypes
  - Hemagglutinin: 16 subtypes
  - Neuraminidase: 9 subtypes
- Highly pathogenic avian influenza (HPA1)
  - H5 and H7
  - H5N1, Asian strain: Human case fatality estimated to be as high as 50%, but not definitely known

# History and Evolution of H5N1 HPAI Viruses

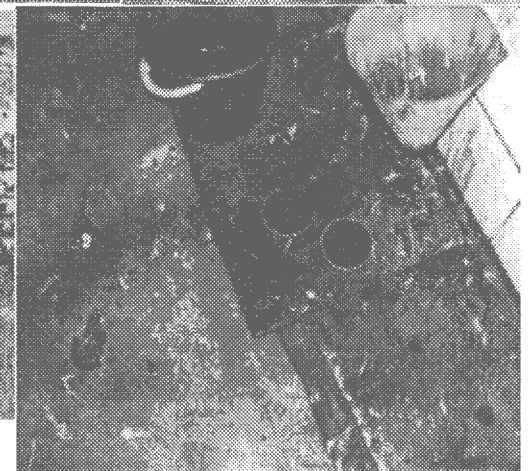
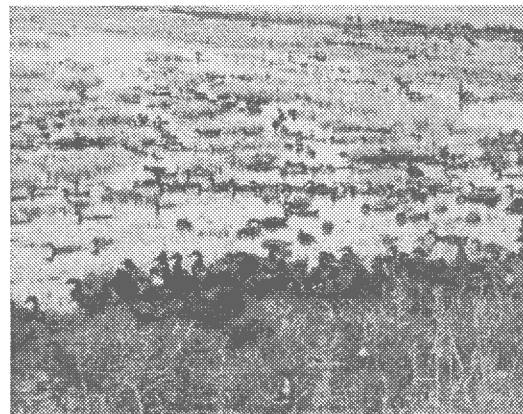
Key epidemiological findings:

- Nomadic or free-range ducks

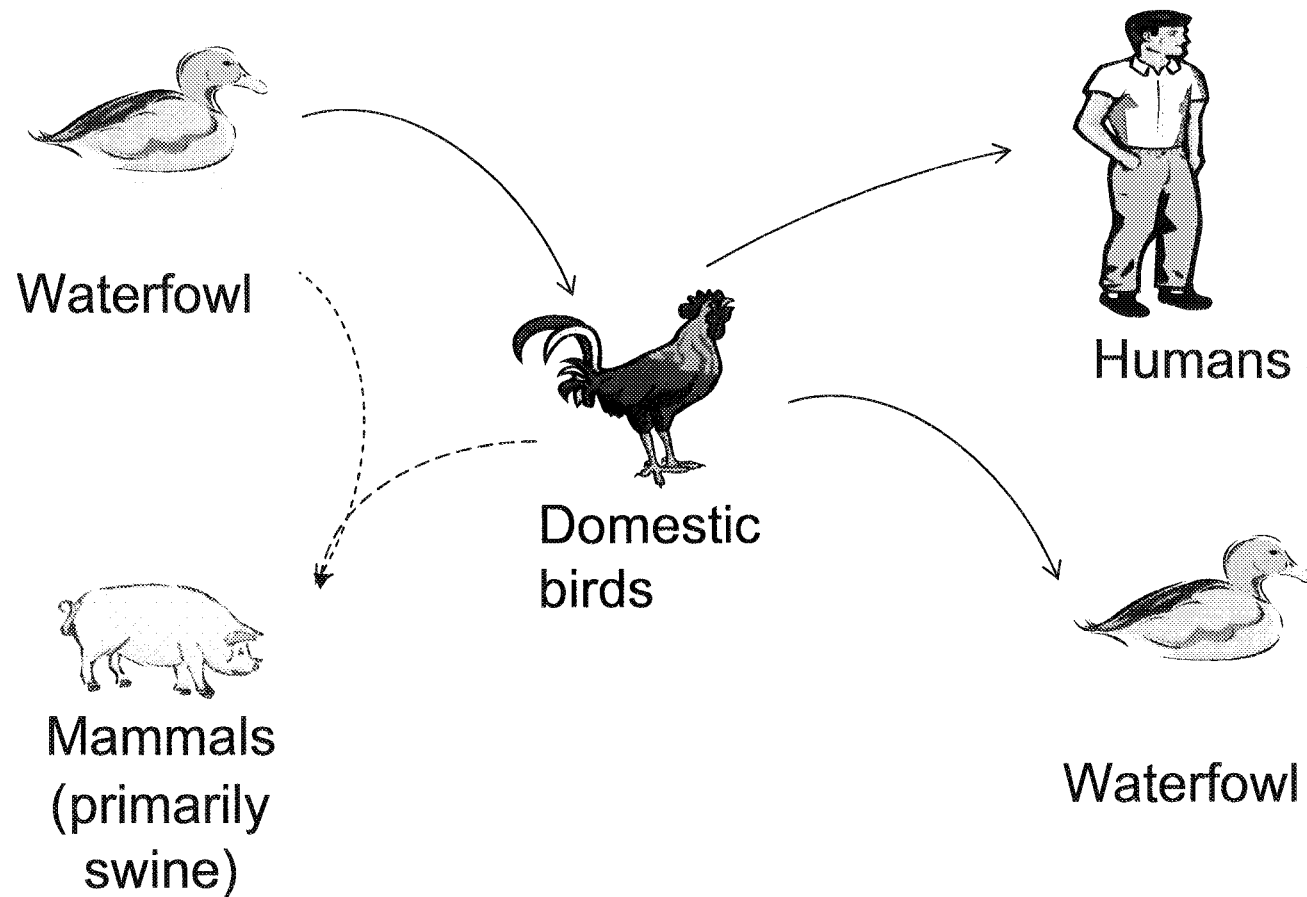
- Contact wild waterbirds
- Virus shedding and spreading
- Reservoir of infection

- Live bird markets

- Cultural practices

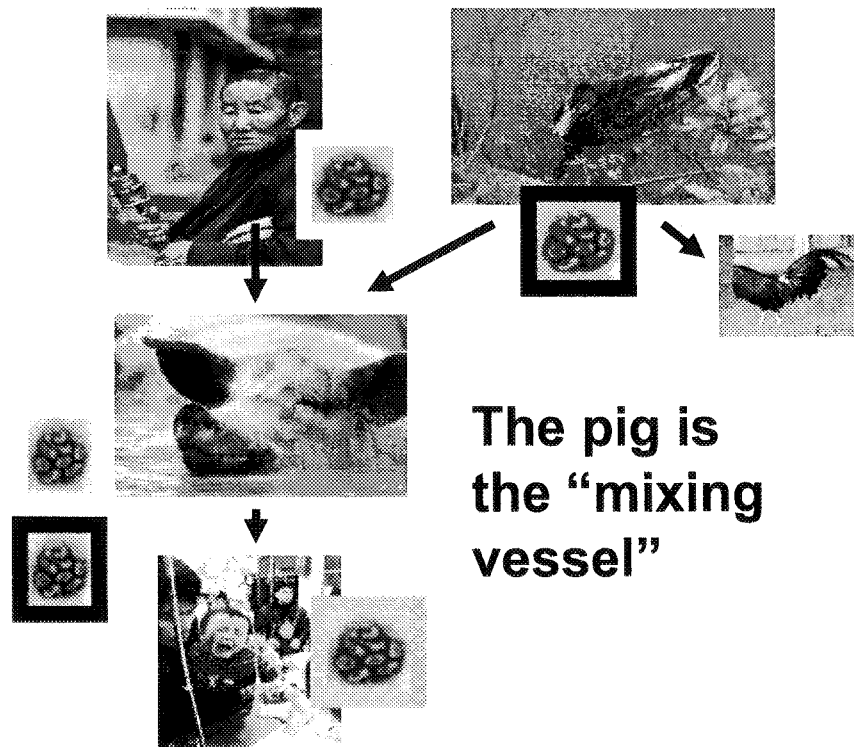


# Cycles of the Asian H5N1 Virus in Animals and Humans

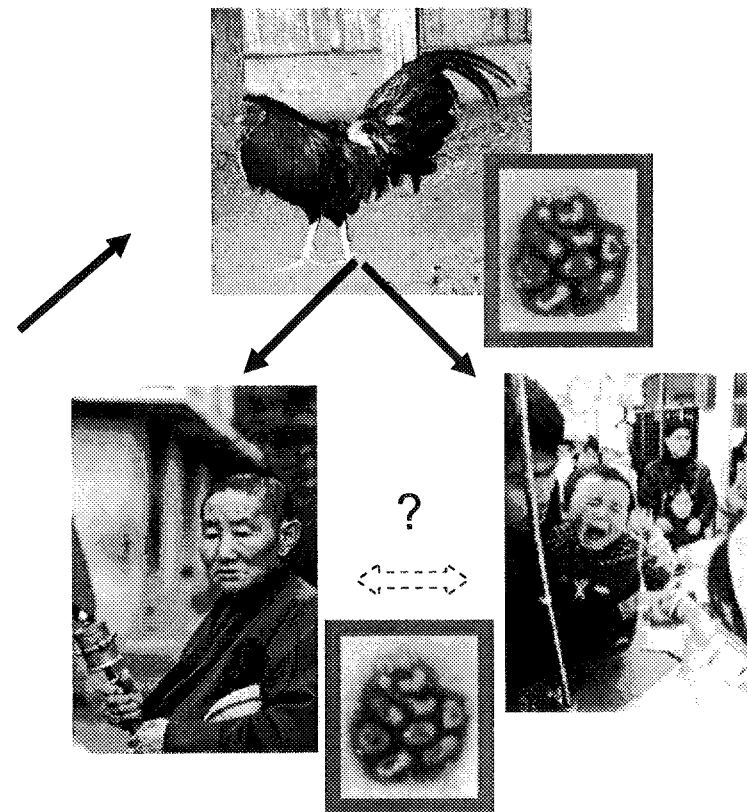


# Why H5N1 is of Particular Concern

Traditional belief of antigenic shift leading to pandemics of human influenza



H5NI influenza is able to infect humans directly

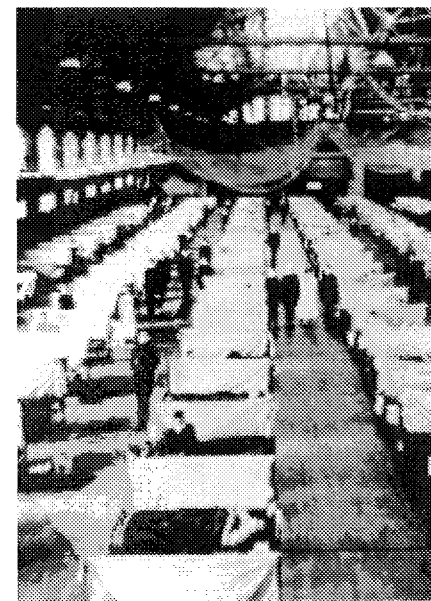


# Potential for Influenza Pandemics

- All influenza viruses can mutate
- Avian flu can cause illness in humans
- If avian viruses acquire human genes
  - Facilitate efficient person-to-person transmission
- H5N1 of particular concern

# Historic Pandemics

- 1918-1919 Spanish Flu
  - Type A virus (H1N1)
  - 20-50 million deaths worldwide
  - 500,000 deaths in the United States
  - Nearly half were young, healthy adults



# Historic Pandemics

- 1957-1958 Asian Flu
  - Type A virus (H2N2)
  - First identified in China February 1957
  - Spread to U.S. by June 1957
  - 70,000 deaths in the United States



# Historic Pandemics

- 1968-1969 Hong Kong Flu
  - Type A virus (H3N2)
  - First detected in Hong Kong early 1968
  - Spread to U.S. later that year
  - Approx 34,000 deaths in the United States
    - Our seasonal flu kills 36,000
  - Virus still circulating today



# **National Strategy for Pandemic Flu**

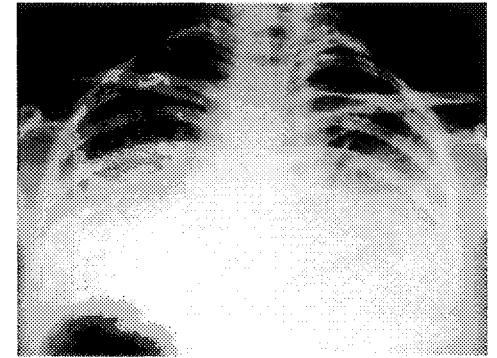
- Preparedness and Communication
- Surveillance and Detection
- Response and Containment

# Request to Fund National Strategy

■ Global surveillance	\$ 251 million
■ Vaccine technology	\$ 2.8 billion
■ Purchase medication and vaccines	\$ 800 million
■ Vaccine for HHS	\$ 1.5 billion
■ Stockpile antivirals	\$ 1.0 billion
■ Emergency preparedness	\$ 644 million
■ Total	\$ 7.1 billion

# Clinical Symptoms - Humans

- **Typical influenza-like symptoms \***  
**(Sudden Onset of)**
  - Fever
  - Sore throat
  - Cough
  - Muscle aches
- **Eye infections\*\***
- **Pneumonia**
- **Acute Respiratory Distress (ARDS)**
- **Other severe and life-threatening complications**



\*Symptoms of bird flu may depend on which virus caused the infection

\*\*H7N7 outbreak in the Netherlands

# **Incubation & Communicability**

- **The virus is spread through droplet nuclei and some airborne**
- **Short incubation period (usually 1-3 days)**
- **Infectious period (usually 3-5 days from clinical onset)\***

**\* It is possible that a portion of all infected people will be infectious even though they have no or mild symptoms.**

# Treatment

- Currently no commercially available vaccine to protect humans
- Antiviral medications:
  - Adamantane derivatives (amantadine and rimantadine)
  - Neuraminidase inhibitors (zanamivir and oseltamivir)\*

\* Oseltamivir (Tamiflu) is the only antiviral not yet rendered ineffective due to viral resistance and recommended by the WHO

# Human Cases of H5N1 Avian Flu 2003-2006

Country	Total Cases	Deaths
Indonesia	27	20
Cambodia	4	4
Thailand	22	14
Vietnam	93	42
China	15	10
Turkey	12	4
Iraq	2	2
Total	175	96

As of 03/09/06 Source: World Health Organization (laboratory confirmed cases)

# H5N1 Outbreak in Birds

## 12/2003 – 03/2006

Countries Affected (confirmed in poultry)

<b>Cambodia</b>	<b>China</b>	<b>Indonesia</b>	<b>Croatia</b>	<b>Slovakia</b>
<b>Kuwait</b>	<b>Japan</b>	<b>Russia</b>	<b>Kazakhstan</b>	<b>Switzerland</b>
<b>Korea (Rep. of)</b>	<b>Thailand</b>	<b>Vietnam</b>	<b>Ukraine</b>	<b>Hungary</b>
<b>Romania</b>	<b>Turkey</b>	<b>Mongolia</b>	<b>Malaysia</b>	<b>Albania</b>
<b>Iraq*</b>	<b>Nigeria</b>	<b>Bulgaria</b>	<b>Greece</b>	<b>Poland</b>
<b>Italy</b>	<b>Iran</b>	<b>India</b>	<b>Egypt</b>	<b>Pakistan*</b>
<b>Austria</b>	<b>Azerbaijan</b>	<b>Germany</b>	<b>France</b>	<b>Serbia &amp; Montenegro*</b>
<b>Bosnia*</b>	<b>Laos*</b>	<b>Slovenia</b>	<b>Niger</b>	

\* - Only H5 confirmed, neuraminidase not determined

**December 2003-March 2006 Source: World Health Organization**

# Avian Influenza in the US

## ■ Delaware (H7N2)

- Reported February 6, 2003
- 12,000 chickens
- Low pathogenicity

## ■ Texas (H5N2)

- Reported February 23, 2004
- First such case in U.S. in 20 years
- 7,000 chickens
- Highly pathogenic

# **What about Avian Flu in Florida?**

- Department of Agriculture and Consumer Services monitors poultry flocks in Florida
- Fish and Wildlife Conservation Commission monitors wild birds
- No avian outbreaks currently detected

# **What is Florida DOH Doing about Avian Flu?**

- Protocol for testing in place between DOH labs and Bureau of Epidemiology; approval required
- Protocol requires detailed history of travel, avian exposure & other risks
- No avian flu testing without clinical history and testing for other respiratory diseases
- Close coordination with CDC; testing not available at private reference labs

# Vaccine and Testing

- Vaccines probably won't be available for months after the start of an epidemic, and there will be limited supplies initially
- Become familiar with testing protocols/procedures for state labs now
- Consider the effect of an epidemic on the lab workforce

# How is Bird Flu Monitored?

- WHO and CDC maintain regional labs that test both bird and human specimens
- The World Health Organization for Animal Health (OIE) test bird samples
- Periodic updates are provided
- The lab surveillance permits implementation of control measures if needed
- Vaccine trials are underway for the H5N1 strain, but are in early phases

# Existing Influenza Surveillance in Florida

- Purposes of current surveillance system:
  - Monitor beginning, peak and end of season
  - Determine which viruses are causing illness
- Network of sentinel physician practices
  - Influenza-like illness as percentage of office visits
  - Influenza cultures in selected practices
- Influenza culture specimens received, positive results, at state Public Health laboratory

# **Additional Surveillance Needed in Case of an Influenza Pandemic**

- Daily tallies of ED visits, hospital admissions, and deaths
  - Total
  - Due to respiratory illness
- Early in the pandemic, intense, rapid, sensitive surveillance for cases due to the new virus to support case-by-case control measures

# Influenza Planning and Preparedness

- Recent statewide Influenza Summit
- Existing Influenza plan dated March 2004
- Draft White Paper 9/05 addresses salient policy issues
- Draft Influenza Pandemic Annex to DOH Emergency Operations, Version 9
- There are substantial training needs

# What Must Be Done: Public Health

- Global surveillance
- Understand human-animal interface
- Rapid genome sequencing
- Epidemiologic models for communities and states
- An effective intervention strategy to reduce transmission of disease

# **What Must Be Done: Healthcare Professionals**

- Heightened awareness
- Seek consultation from your local county health department or the Bureau of Epidemiology for suspect cases
- Consider avian influenza in travelers returning from countries with cases in humans, collect specimens for culture, and notify public health authorities
- Continued education and training

# Pandemic Influenza: Issues

- All communities in Florida and likely throughout the U.S. will be affected at the same time
- Each community will have to deal with the pandemic mostly on their own
- Society as a whole will have to work together to minimize the impact of the pandemic

## **RUSSELL FENDLEY**

As Senior Vice President of Governmental Affairs, Russell Fendley is responsible for representing FHC Health System, and its subsidiary businesses, in their relationships with the federal and state governments. In addition Mr. Fendley serves as a fellow at the National Governor's Association Center for Best Practices, providing policy consultation on healthcare and Medicaid issues.

Mr. Fendley has twenty years of experience in the healthcare field. Prior to joining FHC Health Systems, he served as a health policy advisor for the "Fletcher for Governor" campaign in Kentucky and led a Medicaid Modernization Task Force. Upon election Governor Fletcher asked Mr. Fendley to serve as a member of his transition team, and as Commissioner of the Medicaid program. As Commissioner, Mr. Fendley was instrumental in the development and implementation of Governor Fletcher's Medicaid Modernization Plan, widely regarded as a model for other states to follow. He also successfully implemented policies that saved the Commonwealth over \$350 million dollars while at the same time restoring eligibility to over 3500 Kentuckians affected by previous cost cutting measures. He also served as Chief Operating Officer of a 75,000 member health maintenance organization. Under his leadership the health plan received the honor of being one of the first NCQA fully accredited health plans in the country.

Additionally, Mr. Fendley served as the Kentucky Division Vice President for Columbia HCA Hospital Corporation. In this role he negotiated managed care agreements for the division's 13 hospitals resulting in over \$100 million in gross revenue. He also developed and negotiated the employee health benefits for Columbia's 15,000 Kentucky Division employees. While in this role Mr. Fendley also served on the Board of Director's of each regional Medicaid HMO developed under the states 1115 waiver.

Mr. Fendley received his Masters in Public Administration from Eastern Kentucky University and a B.A. in Political Science from Georgetown College.



# Avian Flu and Special Needs Populations

How to plan for their healthcare needs  
in light of a potential pandemic



## Lessons from Katrina

- Individuals with special needs cannot simply be relocated away from support services and routines.
- Care must be taken that necessary medications are available with little or no disruption.
- Unlike the general population, the loss of medical records could have dire consequences. At the very least there is considerable expense as diagnostic tests are performed again.

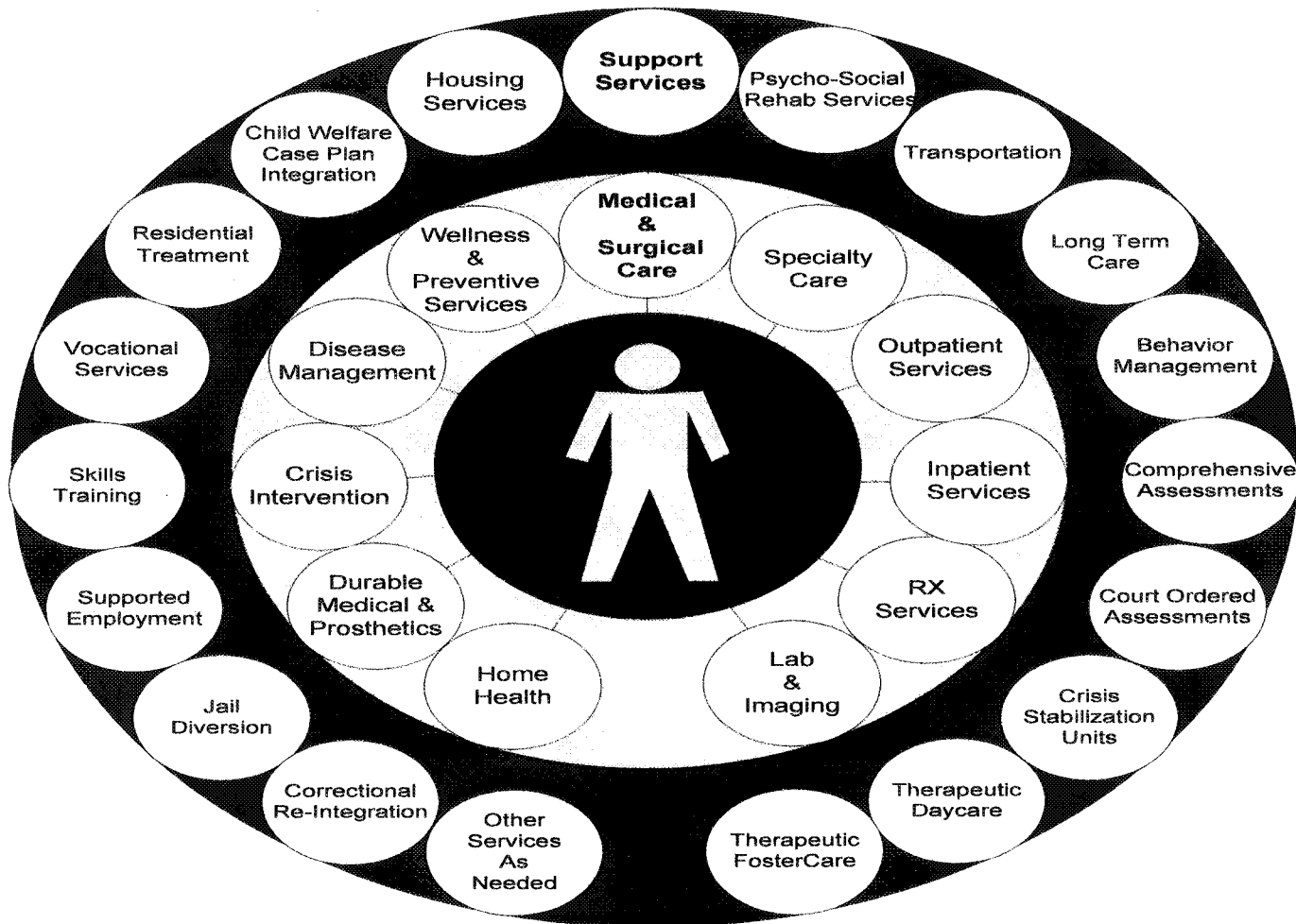


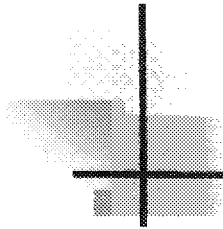
# Lessons from Katrina

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- The only effective plan of dealing with a crisis affecting this population, whether it is a natural disaster or pandemic, is to establish a “no wrong door” system of medical and social supports.
- This system breaks down barriers between different service providers and directly attack the problem of care fragmentation.
- There is **NO** wrong door.

This model provides flexible services tailored to an individual need.





# What are “Special Needs Populations”

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- Severely and persistently mentally ill
- Developmentally disabled
- Institutionalized
- Individuals with severe and disabling chronic conditions



# Risk

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- According to a study by the Special Olympics, persons with intellectual and developmental disabilities have a 40% greater risk of contracting a communicable disease like avian flu.
- These disparities result from lack of physician access, ability to pay, and poorly developed or supported behaviors to promote health.

## **CRAIG FUGATE**

As the Director of the Florida Division of Emergency Management (DEM), Craig Fugate oversees a 134 person agency with an annualized budget of \$425 million dollars. The Division coordinates disaster response, recovery, preparedness and mitigation efforts with each of the state's 67 counties and local governments.

Appointed by Governor Jeb Bush in 2001, Director Fugate also serves as the State Coordinating Officer, responsible for the management of the State Emergency Response Team (SERT), as well as the administration of federal disaster recovery and Homeland Security grant programs. In September 2003, the Florida Emergency Management Program became the first state emergency management program in the nation to receive full accreditation from the Emergency Management Accreditation Program.

Fugate's career in public service began in north-central Florida where he served as volunteer firefighter, paramedic, and lieutenant with the Alachua County Fire Rescue. After rising through the fire service ranks, Mr. Fugate served for ten years as the Emergency Manager for Alachua County, Florida.

In May of 1997, he was appointed Chief of the Bureau of Preparedness and Response with the Florida DEM. In his role as the Chief of the State Emergency Response Team, Fugate directed the state's response operations during floods, tornadoes, the 1998 wildfires, and Hurricane George resulting in over 200 days of activation for the state team.

During the Summer of 2004, Fugate, now in his second term as DEM Director, lead the largest combined disaster response in Florida history with one tropical storm and four hurricanes impacting the state during a six-week period. While this unprecedented recovery operation continues, Director Fugate and the State Emergency Response Team stand ready to respond to Florida's next disaster.

In addition to emergency management, Craig and his wife Sheree are avid sea kayakers.

## **DR. RICHARD SLEVINSKI**

Dr. Richard Slevinski currently serves as the President of the Florida Emergency Medicine Foundation. He sits on the Board of Directors for the Florida Chapter of the American Heart Association, Chairman of the Cardiac/Stroke Committee of the Florida AHA, practicing emergency medicine at Sacred Heart Hospital, Pensacola, Florida, and Medical Director for Florida DMAT-1 (FEMA and Florida Disaster Medical Assistance Team).

He received his degree in medicine from the University of Florida, School of Medicine. He became Board Certified in Emergency Medicine in 1990 and 1999. Dr. Slevinski served as the EMS Medical Director for the State of Florida, Bureau of Health from 1988 to 2004.

He participated in the structure and development of the Emergency Management System in Florida and Nationwide. He authored the first course on EMS Medical Direction that has become the world standard and taught by the National Association of EMS Physicians. Dr. Slevinski also helped develop the parameters of education for emergency medical technicians and paramedics, and was one of the first medical directors for a paramedic teaching program in the state. He has continuously worked to develop the Trauma Care System in Florida and chaired the first statewide conference in 1980 on statewide development of Trauma Centers.

Dr. Slevinski was the recipient of the Ronald Stewart Award from National Association of EMS Physicians in 1991, for his development of the National EMS Medical Directors course, which is their highest award for achievement. That same year, he was also received the State of Florida EMS Medical Director of the Year Award. Dr. Slevinski has received several other awards including the Florida College of Emergency Physicians 1993 Member of the Year, the American College of Emergency Physicians 1996 National EMS Award, and the American Heart Association/American Stroke Association 2000 Stroke Advocate of the Year award.

Health Transformation Summit  
Pandemic Flu Breakout Session  
Dr. Richard Slevinski

Key Facts in Florida:

**Number of ED visits last year?** 7.2 million in 2004 (Source: FHA.org)

**Florida population?** 17,397,161 estimated 2004 population (Source: Census.gov)

**Number of tourists?** 85.8 million in 2005 (Source: VisitFlorida.org)

**How many hospitals?** 285 in Florida – 183 w/ Emergency Departments (Source: FHA.org)

**How many hospital beds?** 64,264 total hospital beds in Florida (Source: FHA.org)

**How many beds in the ED?** 12,360 “trauma beds” (Source: FHA.org)

**How many ER Physicians?** 1,778 combined FCEP members and BC non-members (Source: FCEP)

How can Florida prepare:

- Have a surveillance program adopted and in place now
  - The key to preventing the spread is being able to catch the outbreak before it moves into the general population
- Be prepared to control the flow of information
  - It will be critical to inform people to take reasonable steps to protect themselves and to prevent the spread of the disease
  - The state should be prepared to use the media to inform the people on what steps to take
    - Stay indoors
    - Wash hands
- Establish interstate agreements for aid
  - It is expected that an outbreak will tap our already strained resources
  - An outbreak will also limit the availability of providers, since a portion of the force will succumb to the disease
  - The state should have in place working agreements for personnel and material to be shipped in from other states, similar to how Florida aided other states during their disasters

Statement of

David C. Seaberg, M.D., C.P.E., F.A.C.E.P.

Professor and Associate Chairman,  
Department of Emergency Medicine,  
University of Florida

Board of Director,  
American College of Emergency Physicians (ACEP)

before the

House Committee on Homeland Security  
Subcommittee on Prevention of Nuclear and Biological Attack  
Subcommittee on Emergency Preparedness, Science, and  
Technology  
U.S. House of Representatives

Hearing on

"Protecting the Homeland: Fighting Pandemic Flu From the Front  
Lines"

Presented  
February 8, 2006

## Introduction

Mr. Chairmen and members of the subcommittees, I want to thank you for allowing me to testify today on behalf of the American College of Emergency Physicians at this joint hearing entitled, "Protecting the Homeland: Fighting Pandemic Flu From the Front Lines."

ACEP is the largest specialty organization in emergency medicine, with over 23,000 members who are committed to improving the quality of emergency care through continuing education, research, and public education. ACEP has 53 chapters representing each state, as well as Puerto Rico and the District of Columbia, and a Government Services Chapter representing emergency physicians employed by military branches and other government agencies.

Emergency departments act as our nation's health care safety net. Unlike any other health care provider, the emergency department is open for all patients who seek care, 24 hours a day, 7 days a week, 365 days a year. We provide care to anyone who comes through our doors, regardless of their ability to pay. At the same time, when factors force an emergency department to close, it is closed to everyone and the community is denied a vital resource.

As the frontline of emergency care in this country, emergency physicians are particularly sensitive to the devastating impact an avian flu pandemic would have on our patients and our communities. To put this in perspective, I would like to share with you the findings of the Centers for Disease Control and Prevention:

"In the absence of any control measures (vaccination or drugs), it has been estimated that in the United States a 'medium-level' pandemic could cause 89,000 to 207,000 deaths, 314,000 to 734,000 hospitalizations, 18 to 24 million outpatient visits, and another 20 to 47 million people being sick. Between 15% and 35% of the U.S. population could be affected by an influenza pandemic, and the economic impact could range between \$71.3 and \$166.5 billion."<sup>1</sup>

As this statement indicates, if the avian flu pandemic, which has been the focus of world attention over the past several months, should begin spreading from human to human and then reach our shores, the consequences to the United States would be catastrophic. What makes a potential avian influenza pandemic so deadly is that, like some biologic agents, it would be transmissible from person to person and could spread rapidly in an urban environment or through mass transportation. Optimally, treatment must be initiated as quickly as possible, although contracting avian flu would not result in obvious characteristics that would distinguish it from the normal flu initially. Therefore, detecting it, even when symptoms occur may be difficult.

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<sup>1</sup> Centers for Disease Control and Prevention. January 17, 2006 "Pandemic Flu: Key Facts"

The state of readiness in our nation's emergency departments and the ramifications of patients who have been infected with the avian flu virus appearing at hospital emergency departments around the country are what I will explore in my testimony today.

#### Patient X

Let me give you an example of what could be a typical avian influenza outbreak scenario. Patient X unknowingly contracts the avian flu while on a business trip in Europe immediately prior to boarding a plane for Atlanta. Not only will this person infect the passengers of this plane and anyone else who comes into contact with this individual at one of the busiest airports in the world, but the passengers who have final destinations outside Atlanta will also carry the infection to other passengers, and so on, as the disease begins to spread exponentially. Of course, it will take several days for this person to feel sick enough that they go to their local emergency department.

This infected patient now sits in a typically overcrowded emergency department spreading the infection to everyone else in the waiting room and they, in turn, will either eventually be admitted to the hospital or treated and released to go home and spread the infection to their family and neighbors. Even once they are admitted to the hospital, the majority of patients still remain in the emergency department (also known as "boarding" a patient in the emergency department) waiting for an inpatient bed for more than four hours, with nearly 20 percent of those patients waiting in the emergency department for more than eight hours<sup>2</sup>, which would continue to expose these infected individuals to other emergency department patients, as well as patients throughout the hospital due to the high-volume of air recirculation.

While it is common practice to ensure a patient who enters the emergency department with a cough or fever wears a mask while waiting to be treated, it may take over an hour before a triage nurse has an opportunity to see that individual if the emergency department just received multiple ambulances and the waiting room is already saturated. In addition, the patient may require oxygen treatment and a nebulizer, making the use of a mask irrelevant, and it was the use of nebulizers that caused SARS to spread so rapidly through emergency rooms in 2003.

Without sufficient warning, emergency physicians and nurses would be unprepared to place arriving avian flu patients in isolation until it was too late. Since most hospitals only have one isolation unit, there would be no way to isolate the next patient infected with avian flu. By this time, the emergency physicians and nurses have also been in contact with avian flu and, unless they have been previously inoculated, would be at high-risk of contracting the disease themselves, potentially diminishing their ability to provide care for incoming patients.

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<sup>2</sup> General Accounting Office. GAO-03-460. March, 2003 "Hospital Emergency Departments: Crowded Conditions Vary among Hospitals and Communities."

### Overcrowding and Lack of Surge Capacity

As the disease begins to spread rapidly among the population, the strain will cripple America's 4,000 hospital emergency departments as the majority of the nation's emergency departments are already operating either at or over critical capacity. Emergency department visits rose more than 26 percent in a decade – from 89.8 million in 1992 to 114 million in 2003. At the same time, the number of emergency departments decreased by 14 percent.<sup>3</sup> In addition, between 1990 and 1999, hospitals lost 103,000 staffed, inpatient medical/surgical beds and 7,800 Intensive Care Unit (ICU) beds.<sup>4</sup> As a result, fewer beds are available for admissions from the emergency department. Once the emergency departments have filled all of their beds, there is no reasonable way to expect that these stressed systems will be able to suddenly create the surge capacity necessary to effectively manage a pandemic, natural disaster, terrorist attack or other mass-casualty event.

When crowding becomes so severe that patient safety could be jeopardized, ambulances must be diverted to other hospitals, potentially causing precious time to be lost. In 2001, two-thirds of emergency departments diverted ambulances to other hospitals. Because overcrowding is most severe in areas with large populations (where the potential spread of infectious disease poses the greatest risk), nearly one in 10 hospitals reported being on ambulance diversion 20 percent of the time (more than four hours per day).<sup>5</sup>

### Need for Effective Syndromic Surveillance

Knowing about an avian flu outbreak elsewhere in the world or here in the United States could significantly improve preparations and reduce diagnosis time. For this reason, it is essential that our nation have a real-time syndromic surveillance system linking emergency departments across regions with state public health departments and nationally with the Centers for Disease Control and Prevention to serve as an early warning system for epidemics. Existing data collection systems are currently limited in their capacity and ability to provide information to health authorities and the public. Until such time that we do have an effective means of data collection and dissemination, emergency physicians and nurses will serve as critical components of the nation's human syndromic surveillance system.

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<sup>3</sup> Centers for Disease Control and Prevention Advance Data from Vital and Health Statistics "National Hospital Ambulatory Medical Care Survey: 2003 Emergency Department Summary." No 358. May 26, 2005.

<sup>4</sup> "Emergency Departments: An Essential Access Point to Care," *AHA Trendwatch* 3, no. 1 (2001): 1–8.

<sup>5</sup> General Accounting Office. GAO-03-460. March, 2003 "Hospital Emergency Departments: Crowded Conditions Vary among Hospitals and Communities."

## Planning and Preparedness

Detection of a disaster, act of terrorism or epidemic will only be effective if appropriate preparations have been made at all levels of government and the private sector. In most disasters, the emergency department is the frontline. History has shown that during a disaster, such as 9/11 or the anthrax scare here in the nation's capital, nearly 80% of patients simply go to the nearest emergency department, bypassing ambulance transport. In fact, only a small percentage of patients are actually managed by EMS. Emergency department personnel are the forgotten first line of response in disasters.

Since 9/11 we have appropriately spent billions on preparedness. But emergency departments have received virtually none of that support. Policymakers and the public have assumed that the nation's emergency departments will be able to meet their vital safety net function. However, lack of overall capacity may lead to a breakdown of the health care safety net when we need it most. If we are unable to effectively respond to a disaster or pandemic, people will suffer needlessly and some will die.

The private sector also will play an important role before and during an avian flu pandemic. In addition to providing goods and services to the public and medical personnel, workplace policies that diminish the potential spread of infectious diseases are critical. Establishing an ethic of infection control in the workplace that includes options for working offsite while ill, systems to reduce infection transmission and worker education are vital.

## ACEP Recommendations

We must take steps now to avoid a catastrophic failure of our medical infrastructure and we must take steps now to create capacity, alleviate overcrowding and improve surge capacity in our nation's emergency departments.

My colleagues and I at the American College of Emergency Physicians present this 10-point plan to achieve these goals and we urge Congress to enact these measures in order to effectively manage a pandemic, natural disaster, terrorist attack or other mass-casualty event.

1. We must increase the surge capacity of our nation's emergency departments by ending the practice of "boarding" admitted patients in emergency departments because no inpatient beds are available. This will require changing the way hospitals are funded to allow for inpatient and intensive care unit surge capacity to manage this burden.
2. We must implement protocols to collect and monitor real-time data for syndromic surveillance, hospital inpatient and emergency department capacities and ambulance diversion status. Collection of this data is vital to developing appropriate protocols.
3. Homeland Security agencies on the Federal, State, and Local levels need to understand that hospitals and Emergency Departments are part of the community's

- Critical Infrastructure. We can not have response and recovery in a disaster without fully functioning, protected, and connected health resources.
4. We must require hospitals and communities that are severely affected by a natural or man-made disaster, or even a severe influenza outbreak, to postpone elective admissions until the crisis has abated. We must develop a way to compensate those facilities for their loss of revenue.
  5. Command and control of disaster medical response must be more coordinated across federal, state and local agencies and departments.
  6. We must establish a committee of stakeholders and disaster medicine experts from the public- and private-sectors and academic institutions to develop and/or refine national medical preparedness priorities and standards. We must change the national preparedness culture to one which is consensus-driven and evidence-based.
  7. We must provide federal and state funding to compensate hospitals and emergency departments for the unreimbursed cost of meeting their critical public health and safety-net roles to ensure these emergency departments remain open and available to provide care in their communities.
  8. We must establish a sustainable funding mechanism for disaster preparedness for hospitals, emergency departments and emergency management that is tied to national benchmarks and deliverables.
  9. To ensure emergency physicians and nurses play a primary role in disaster planning and are considered in any national allocation of resources and protective measures, Congress should continue to include them in any definitions regarding first responders to disasters, acts of terrorism and epidemics.
  10. Congress should pass H.R. 3875, the "Access to Emergency Medical Services Act," which provides incentives to hospitals to reduce overcrowding and provides reimbursement and liability protection for EMTALA-related care.

## Conclusion

While adopting crisis measures to increase emergency department capacity may provide a short-term solution to a surge of patients suffering from the flu, ultimately we need long-term answers. The federal government must take measures necessary to strengthen our resources and prevent more emergency departments from being permanently closed. In the last ten years, the number and age of Americans has increased significantly. During that same time, while visits to the emergency department have risen by tens of millions, the number of emergency departments and staffed inpatient hospital beds in the nation has decreased substantially.<sup>6</sup> This trend is simply not prudent public policy, nor is it in the best interest of the American public.

Let me close by assuring you that in any local, regional or national disaster or epidemic, the nation's emergency physicians and emergency nurses will be there to do their jobs, as

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<sup>6</sup> Centers for Disease Control and Prevention Advance Data from Vital and Health Statistics "National Hospital Ambulatory Medical Care Survey: 2003 Emergency Department Summary." No 358. May 26, 2005.

"Emergency Departments: An Essential Access Point to Care," *AHA Trendwatch* 3, no. 1 (2001): 1-8

was evident during Hurricane Katrina. If the avian flu pandemic were to spread throughout America before appropriate safety measures could be implemented, then it's reasonable to expect a 20% loss of emergency department personnel due to death or disability. America's emergency departments are already operating at or over capacity. This loss of emergency department personnel is unsustainable and would cripple this nation's health care safety net and the quality of patient care would be severely jeopardized.

Every day we save lives across America. Please give us the capacity and the tools we need to be there for you when you need us... today, tomorrow and when the next major disaster strikes the citizens of this great country.

## **RONALD E. BACHMAN**

Ronald E. Bachman is a Senior Fellow of the Center for Health Transformation (CHT) and a respected actuary with extensive experience in healthcare strategy for payers, providers and employers.

In recent years, Mr. Bachman has focused on the market evolution of the consumer-centric health plan. He has worked on special projects with CHT and Former Speaker Newt Gingrich on health policy issues and market transformation ideas. Mr. Bachman worked closely with the Bush White House and Treasury on the language and principles of the 2002 Health Reimbursement Arrangement (HRA) guidelines. In 2003 and 2004 he worked through CHT to provide policy input on Health Savings Accounts (HSA). He has consulted with various government agencies on national health issues and legislative and regulatory proposals. He has served as a designated expert on actuarial issues to the Centers for Medicare and Medicaid Services, the Congressional Budget Office, the Department of Labor, the National Institute of Mental Health, and several members of Congress.

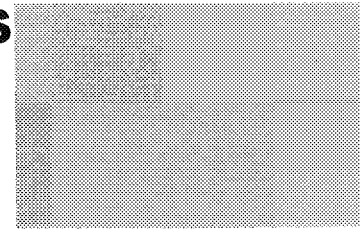
Mr. Bachman is the author of several publications, including “Consumer-Driven Healthcare – The Future in Now”, “Giving Patients More Control” published by the National Center for Policy Analysis. He has written numerous articles such as, “Boomers Will Revise an Aged, Ineffective System” and “Consumer-centric Medicare” both articles co-authored with Newt Gingrich, founder of the Center for Health Transformation.

A Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries, he obtained a Masters in Actuarial Science from Georgia State University and a Bachelor of Science in Applied Mathematics from the Georgia Institute of Technology.

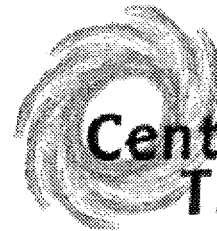
# **Consumer-centric Medicaid in a 21<sup>st</sup> Century Intelligent Healthcare System**

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**An Approach for Savings Lives  
and  
Improving the Health of  
Medicaid Recipients**



**Healthcare Visions, Inc.**  
**Creating the possible...**



**Center for Health  
Transformation**

# **Consumer-centric Medicaid**

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## **To achieve real transformation in Medicaid:**

One program design cannot meet the needs of such distinct and separate groups of beneficiaries –

1. the poor.
2. people with disabilities (Aged, Blind, Disabled), and
3. the frail elderly.

**Consumer-centric Medicaid as described in this presentation focuses on the first group**

# **Consumer-centric Medicaid**

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**Consumer-centric Medicaid is about transforming the health benefit plan into one that puts economic purchasing power—and decision-making—in the hands of participants.**

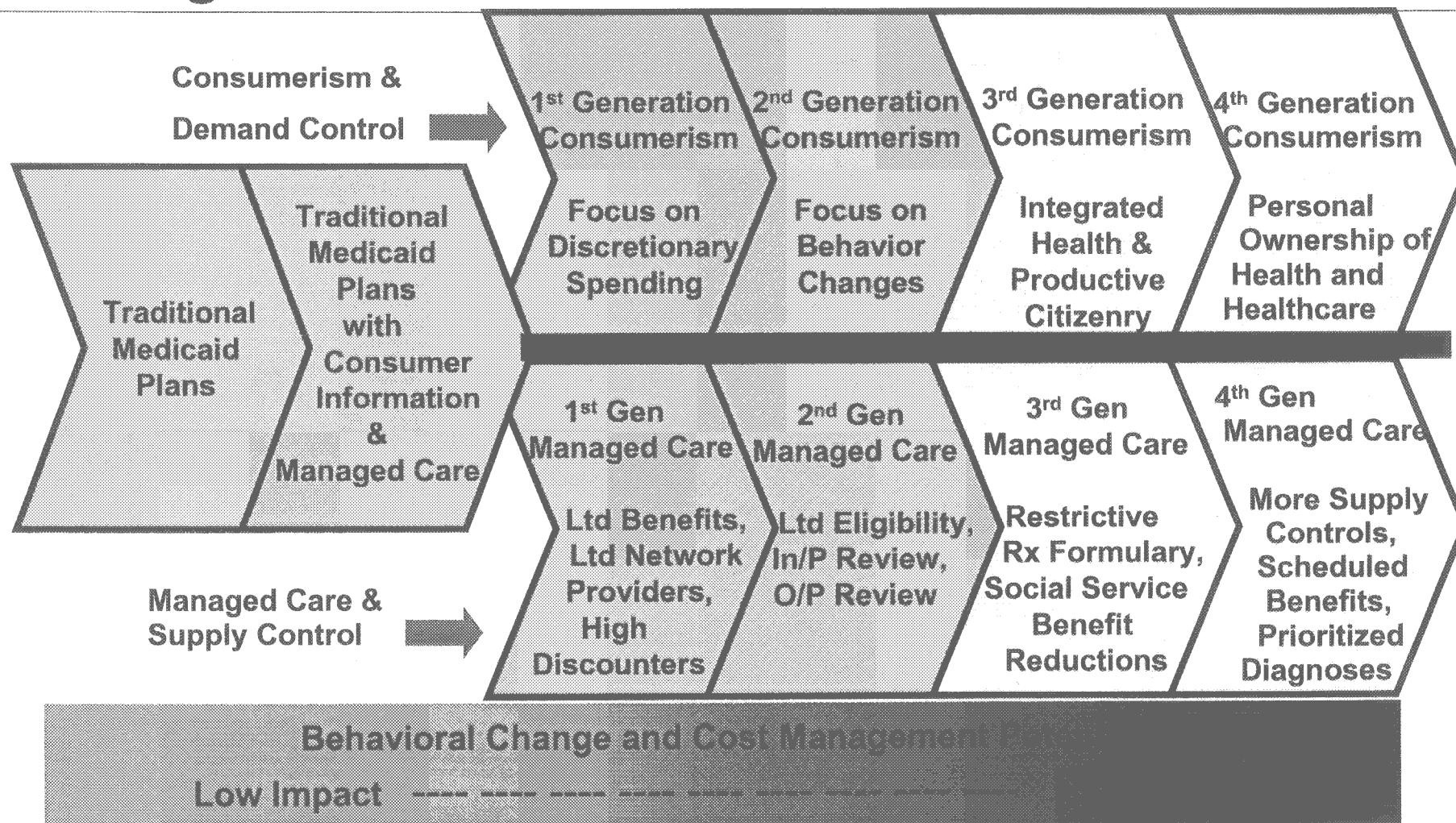
**It's about supplying the information and decision support tools they need, along with financial incentives, rewards, and other benefits that encourage personal involvement in altering health and healthcare purchasing behaviors.**

## **Two Basic Principles for Successful Consumer-centric Medicaid**

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1. Must work for the Sickest Participants,  
as well as the healthy
2. Must work for those not wanting to get  
involved in decision-making, as well as  
the “techies”

# Two Choices for the Future Managed Care or Consumerism

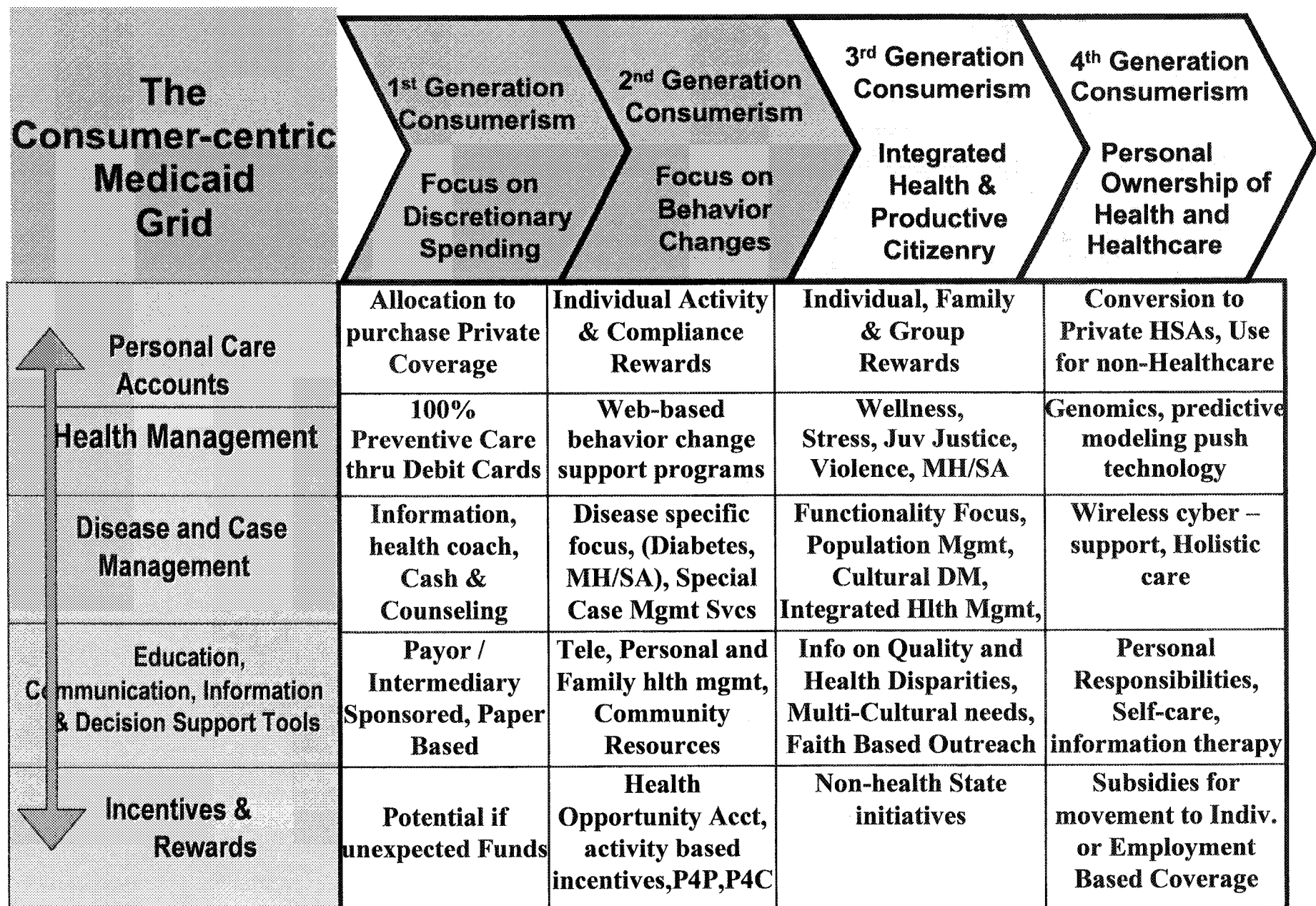


Slide 5

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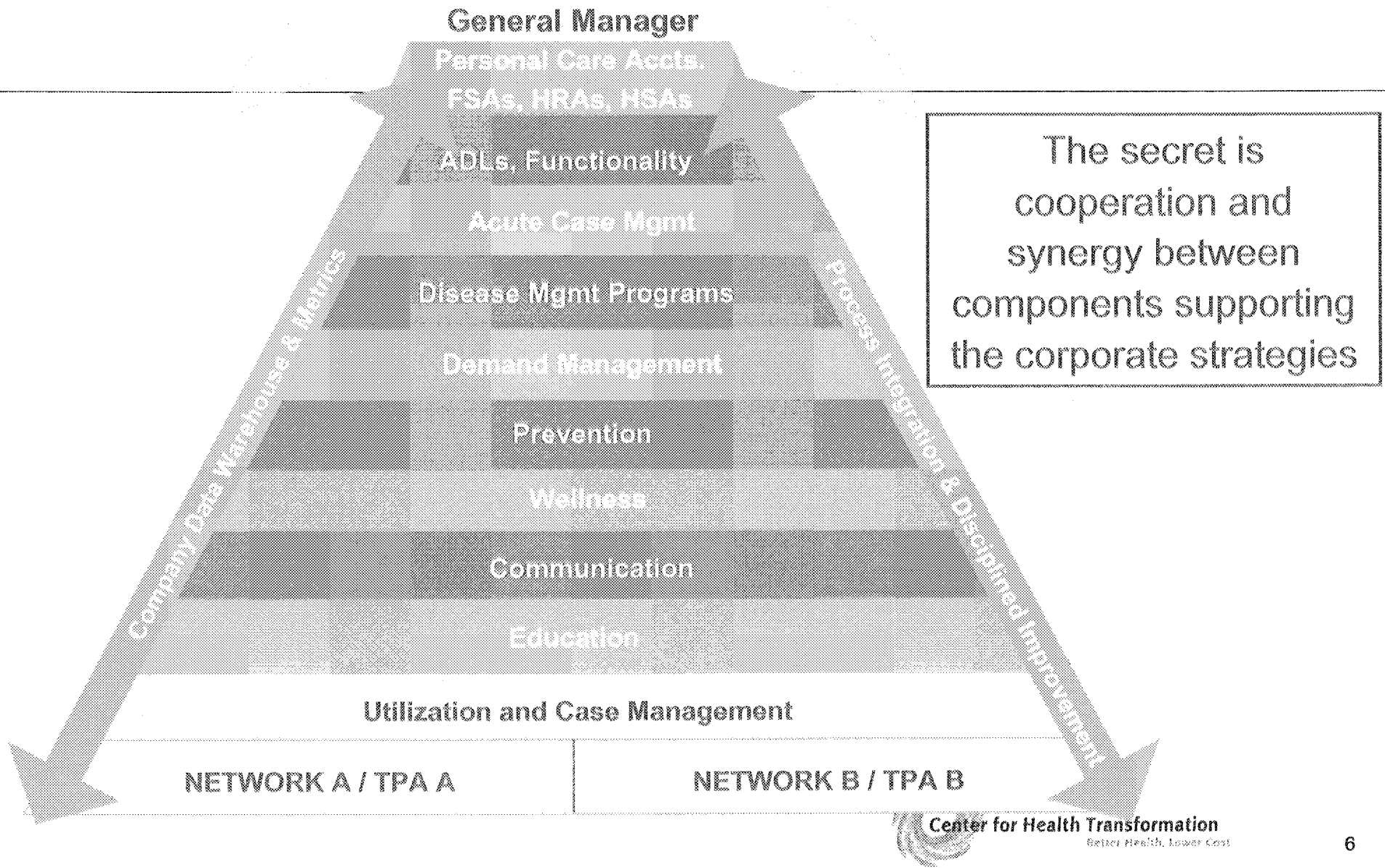
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# Integrated Health Management Program

## An Implementation Option for Multiple Generations



## **CHRISTIE RANISZEWSKI HERRERA**

Ms. Christie Raniszewski Herrera is director of the Health and Human Services Task Force at the American Legislative Exchange Council (ALEC), the nation's largest nonpartisan individual membership organization of state legislators.

In that capacity, Ms. Herrera drives model legislation, conducts research, builds coalition support, and heightens media awareness in support of free-market health care policy. During the 2005 session, sixteen states enacted model legislation drafted by ALEC's Health and Human Services Task Force.

Ms. Herrera previously served for two years as director of public affairs at The James Madison Institute (JMI) in Tallahassee, where she managed policy research, media relations, marketing, and events for the Institute. Prior to joining JMI, she spent three at the Cato Institute, where she directed all policy events at Cato and on Capitol Hill. During the 2000 primary season, she was hired as an assistant budget analyst for Steve Forbes' presidential campaign.

Ms. Herrera has testified before the Oklahoma, Michigan, and Wisconsin legislatures, and her work has appeared in *The Washington Times*, *Congress Daily*, and *Health Care News*. She holds a B.S. in communication studies and an M.S. in political science from Florida State University.

## **DALE BROWN**

Dale Brown is the Senior Vice President of Business Development at MedImpact. He is responsible for sales, account management, marketing, product development, and network strategies. In this role, he also leads the development of strategic alliances that benefit clients and that promote health care transformation.

Mr. Brown brings a broad range of health care industry experience to MedImpact, including extensive pharmacy benefit management industry experience. Most recently, he was the Senior Vice President of Marketing for Cardinal Health's Pharmaceutical Distribution Division. Prior to Cardinal Health, Brown was Vice President of Marketing at Merck-Medco. At Caremark Prescription Services, he was the Director of National Accounts and was the Senior Director of Product Strategy. Additionally, Brown has managed care experience with Humana.

Mr. Brown received a Bachelor of Science degree in Medical Sociology from the University of Illinois, Urbana and a Master of Business Administration degree in marketing and finance from The University of Chicago Graduate School of Business.



# Transformational Solutions

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## Delivering Choices to Medicaid & Government Payors

Dale Brown

SVP, MedImpact Healthcare Systems, Inc.

March 14, 2006

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**MedImpact**  
*Delivering · Flexible · Choice*



# PilotRx

Empowering Prescription Choices

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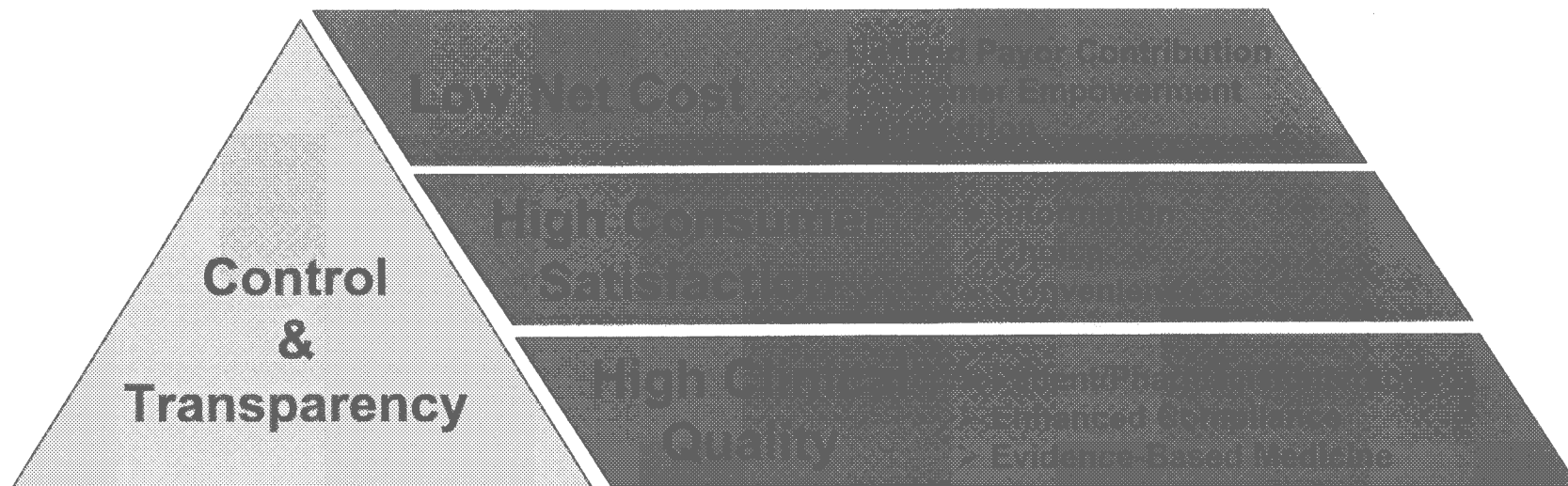


Largest PBM that does not sell drugs

- California corporation
- 27 million lives nationwide
- Transparent PBM since 1989

Online access to savings

- Empowers consumer accountability
- Tool for transparency – for consumer



On prescription drugs,  
PilotRx will save Payors:

44%

Annual savings for  
300,000 lives:

\$28 million



**PilotRx**  
Prescription Drug Savings

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**Welcome to PilotRx**  
PilotRx is an online destination that empowers you, the consumer, to participate in the management of your own healthcare.

**PilotRx Tools**

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**Refill Prescriptions** - Transfer over your existing prescription to a pharmacy of your choice.

**Ask a Pharmacist** - Phone, email, or chat online with a licensed pharmacist.

**Estimate Annual Drug Spending** - Calculate your annual drug expenses.

**Registered users can access:**

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- **Formulary Lookup** - Determine coverage and pricing for medications.
- **Pharmacy Locator** - Find a participating pharmacy near your location.
- **PersonalHealth Rx** - Print your prescription history for a physician visit or tax reporting.

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**PilotRx Information Center**

**Drug Facts** - Learn about the prescription drugs you are taking and get information on prescription and over-the-counter medications.

**Research a Disease** - Your guide to symptoms, diagnosis, treatment, prevention, community, experts, and the latest news.

**Hospital and Critical Care Rankings** - Compare treatment outcomes, costs, and safety for hospitals in your area.

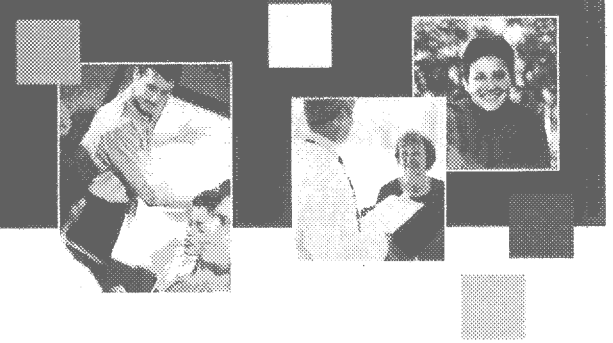
**Recent Drug Alerts**  
Vioxx users can get money for unused medicine.  
Confused by the Medicare Drug Discount Card? You're not alone.  
Why drug companies advertise on TV.  
All Drug Alerts

**Information Center**  
Drug Facts  
Drug Alerts  
Research a Disease  
Hospital and Critical Care Rankings

**APPLY FOR THE MEDICARE USA DRUG DISCOUNT CARD**  
CLICK HERE TO LEARN MORE AND ENROLL

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Delivering • Flexible • Choice

# Benefit Design - After Pay



## With the After Pay Model:

- The **PAYOR** pays 100%:
  - For the lowest cost drug;
  - That is clinically appropriate;
  - At the lowest cost pharmacy.
- The **CONSUMER** pays nothing,
  - And is more likely to be compliant.
- However, if the **CONSUMER chooses** a higher cost drug and/or a higher priced pharmacy,
  - She pays the price difference between the lowest cost drug and the drug of her choice.

# After Pay Model Example



		Traditional PBM Copay Model		PilotRx After Pay Model	
	Total Cost of Drug	Member Cost	Plan Cost	Member Pays	Plan Pays
Lowest Cost Generic	\$25	\$5	\$20	\$0	\$25
Brand Drug	\$100	\$20	\$80	\$75	\$25



# Choice60<sup>Rx</sup>

The information contained in this presentation is intended for dissemination to business partners of MedImpact Healthcare Systems, Inc., only. Any other unauthorized use is strictly prohibited.

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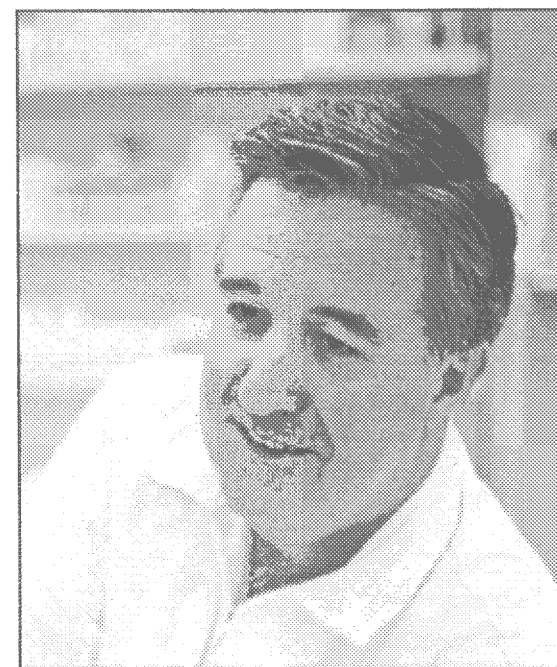
By simply providing **Choice60<sup>Rx</sup>** to the  
Medicaid Population . . .

**Government Payors will save  
\$17,200,000 annually\***

. . .while aligning consumer goals with  
Medicaid reform goals:

- Low Net Cost
- High Quality of Care
- High Satisfaction

\*For approximately 1,000,000 lives

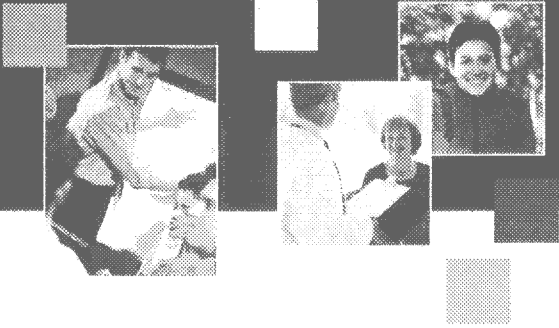


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- Restricted to 30-day prescriptions – higher price
- Transient population
- High incidence of chronic medications
- No 90-day option – waste concern





Medicaid recipients have the **choice** and **flexibility** to obtain a **60-day supply** of maintenance medication from their **local** pharmacy.

Choice**60**<sup>Rx</sup>

- 60-day benefit for long-term prescriptions
- Face-to-face consultation
- Greater discount
- Less waste



# Transformational Solutions

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## Delivering Choices to Medicaid & Government Payors

**Dale Brown**  
**SVP, MedImpact Healthcare Systems, Inc.**  
**March 14, 2006**

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## **RANDY KAMMER**

Ms. Randy Kammer is Vice President of Regulatory Affairs and Public Policy for Blue Cross Blue Shield of Florida, Inc (BCBSF). She has been with BCBSF for almost 19 years. Prior to that, she was Senior Staff Attorney, Three Rivers Legal Services, Inc., Gainesville, Florida, from 1979 to 1987. Ms. Kammer is President of BCBSF's, *The Blue Foundation for a Healthy Florida*. She recently served as co-chair of the Department of Insurance Small Group Standard Benefit Design Committee and chaired the committee in the early 1990's. She is secretary of JaxCare (a public/private partnership to insure low-income workers), Secretary of the Florida Life and Health Insurance Guaranty Association, and is on the steering committee of the Center for Practical Health Reform.

Ms. Kammer serves on the board of Three Rivers Legal Services and is very active in the Jacksonville Jewish community. She currently serves on the Jewish Community Alliance Board, as well as the Temple Board of Trustees and the River Garden Nursing Home Board.

She has a B.A. from Northwestern University and a J.D. from the University of Florida College of Law. She is a member of the Florida Bar; admitted to practice before the U.S. District Court, North and Middle Districts of Florida; and the U.S. Court of Appeals, 11<sup>th</sup> Circuit.

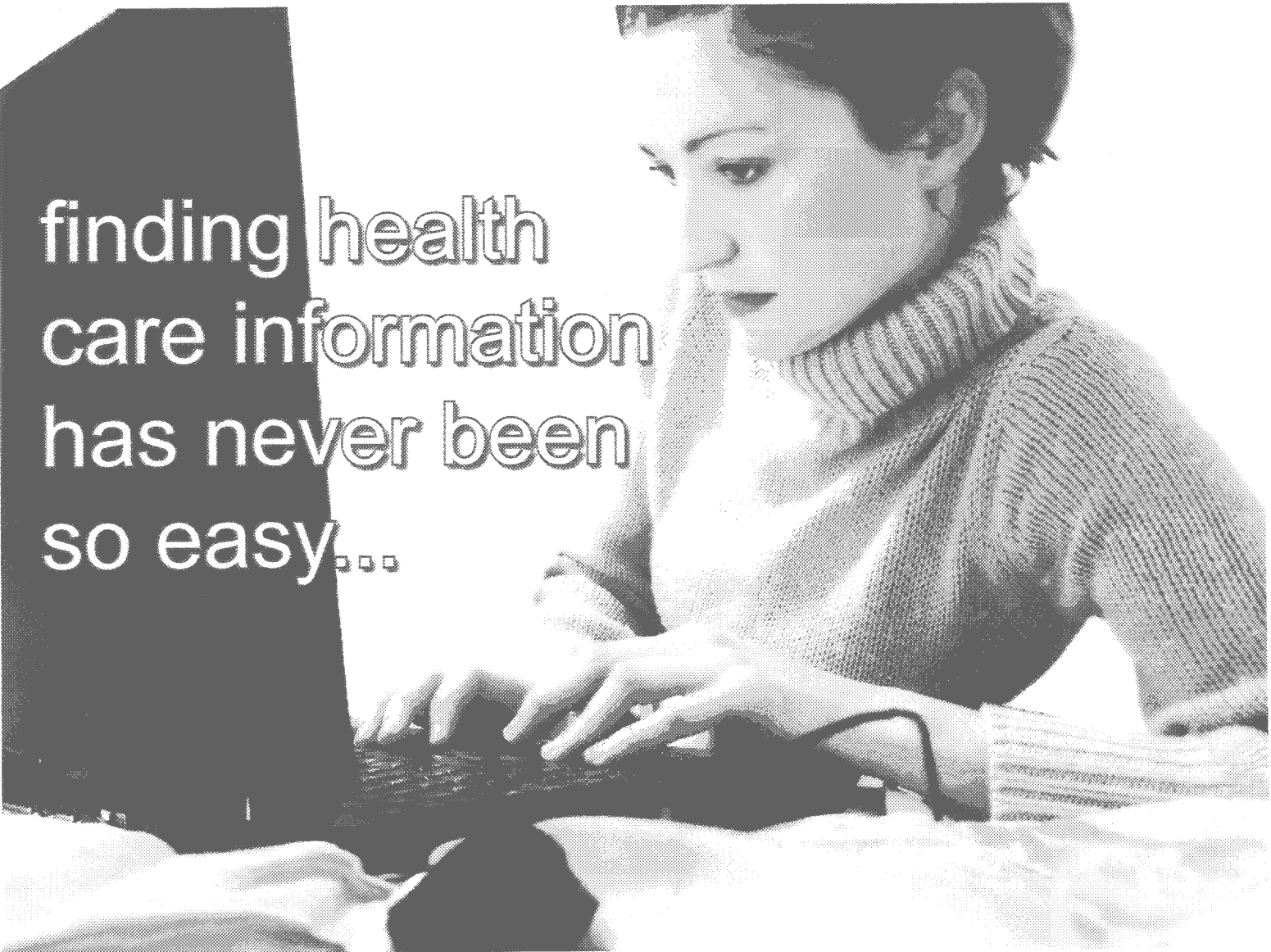
She has one adult daughter, Allison Kammer Phillips.

## **LISA RAWLINS**

Lisa Rawlins is the Bureau Chief for State Center for Health Statistics at the Florida Agency for Health Care Administration (AHCA). Her duties include being responsible for contract management for several contracts with the private and public sectors as it relates to the management of AHCA's State Center for Health Statistics. She directs and manages 40 staff members within the State Center for Health Statistics Bureau in the planning, development, organization, implementation and evaluation of health information systems related to data collection, analysis and dissemination for the State Center for Health Statistics. Ms. Rawlins directs the operations associated with data collection, quality measures, audits, data analysis, data integrity and all aspects of data and information security., and directs the collection of health care data and health care information necessary for the statewide comprehensive health planning.

Ms. Rawlins formerly served at project manager for the Florida Governor's Health Information Infrastructure Advisory Board. She was responsible for coordinating board activities; planning and implementing state level meetings on HIT; researching national and state trends in HIT; preparing policy briefs, and keeping board members abreast of latest developments in the field of health information technology. As a Senior Analyst for the Committee on Health Care at the Florida House of Representatives, she analyzed and summarized proposed legislation as it relates to Medicaid, certificate-of-need, health facility licensure and regulation, Medicaid Managed Care, Emergency Services, county Health Departments, practitioner regulation, and public health initiatives to determine its effectiveness and the impact of its passage on the state and other entities and individuals; research and draft legislation and amendments.

She has held other positions in the legislative and healthcare arena. Ms. Rawlins graduated from Georgia State University in 1983, with a major in biology.

A black and white photograph of a woman with short dark hair, wearing a light-colored turtleneck sweater, sitting at a desk and typing on a laptop. The laptop screen is on the left, and the woman is looking down at her hands. The background is out of focus.

finding health  
care information  
has never been  
so easy...

The 2004 Florida Legislature's landmark legislation mandating public reporting of health care information has been realized through the Agency for Health Care Administration's (AHCA) transparency actions. In order to have all perspectives, the Legislature required AHCA to facilitate and staff the Comprehensive Health Information System (CHIS) Advisory Council. The CHIS is made up of stakeholders including consumers, purchasers (business), hospitals, physicians, and health plans to review and discuss public reporting issues and to advise Secretary Alan Levine on the best practices for public reporting and transparency implementation activities. To support those activities, the CHIS and their corresponding workgroups, which consist of experts in their fields, have volunteered their time to advise Secretary Levine. AHCA and the CHIS Advisory Council were recently recognized by the National Association of Health Data Organizations for Florida's leadership in public reporting of consumer health information.

Leading the Nation in public reporting of health care data, Florida's efforts directly address the goal to improve health care and reduce skyrocketing costs through transparency. By providing Florida's consumers with more user-friendly and comparative health care information, AHCA will help Floridians become the most informed health care consumers in America.

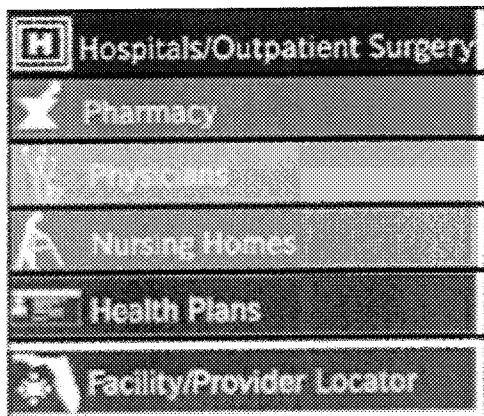
[www.FloridaHealthStat.com](http://www.FloridaHealthStat.com)

[www.FloridaHealthStat.com](http://www.FloridaHealthStat.com), provides health care information to assist consumers, health care professionals, and researchers in making well-informed health care decisions and in researching the status of health care in Florida. The site, established by the Agency for Health Care Administration, includes:

- \* a list of licensed health care facilities and providers in Florida;
- \* detailed information on patient data from hospitals and ambulatory surgery centers;
- \* information on insurance, Medicare, Medicaid, medication;
- \* concerns for seniors and for families;
- \* consumer publications;
- \* statistical health reports, and much more.

Comparative health care data allows everyone to be safety conscious consumers and providers. Visit us today at:  
[www.FloridaHealthStat.com](http://www.FloridaHealthStat.com)

Consumer links on our home page include:



[www.FloridaCompareCare.gov](http://www.FloridaCompareCare.gov)

A national leader in public reporting of health care data, Florida was the first state in the country to publicly report infection rates and one of the first to report complication rates by facility with the November 2005 release of [www.FloridaCompareCare.gov](http://www.FloridaCompareCare.gov), (a part of [FloridaHealthStat.com](http://FloridaHealthStat.com)).

This consumer-focused website provides a clear, transparent view of performance data for selected medical conditions and procedures in Florida's short-term acute care hospitals and ambulatory surgery centers. This search tool assists consumers, health care professionals, and researchers in comparing hospitals and ambulatory surgery centers, including information on quality of care, pricing and performance. [FloridaCompareCare.gov](http://FloridaCompareCare.gov) provides useful information to consumers when choosing a health care facility that best serves their needs and to researchers studying the status of health care in Florida.

[www.MyFloridaRx.com](http://www.MyFloridaRx.com)

Many Florida residents, especially individuals on a fixed income, have to make a choice between purchasing life saving medication or paying their rent or buying their groceries. Policy makers of Florida thought it essential to give consumers a tool for shopping for the best price for prescription drugs.

With the release of the prescription drug website, mandated by the landmark 2004 Affordable Health Care legislation HB 1629, consumers are provided with the retail prices of the top 50-prescribed drugs by pharmacy across Florida. The website, [www.MyFloridaRx.com](http://www.MyFloridaRx.com), is a coordinated effort between AHCA and the Florida Attorney General providing a valuable tool to consumers shopping for the lowest priced prescription drugs. More information about understanding prescription drug prices is also available on: [www.FloridaHealthStat.com](http://www.FloridaHealthStat.com).

These websites are linked for easy access.



State Center for Health Statistics  
2727 Mahan Drive, Tallahassee, Florida 32308